THE CANADIAN NURSE

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Between Ourselves

As a preface to and preparation for the forthcoming biennial convention in Halifax next June, it seemed to the *Journal's* editorial staff that there would be interest and value in providing an opportunity for each of our national committee chairmen to describe succinctly the program her committee had developed during this biennium. The chairmen's replies to our letters of invitation to serve as guest editors in successive issues were prompt and enthusiastic. Sister Mary Felicitas wrote about the nursing service program last month. You can read the comments of Miss E. A. ELECTA MACLENNAN, chairman of the Committee on Legislation, in this issue.

Miss Helen Carpenter is scheduled to unveil some of the problems that have to be considered by the Finance Committee as our National Association strives to match an income based on the per member assessment approved in 1952 against the demands made in 1960.

The least static aspect of nursing in our national scene is the education of student nurses. Two-year programs, plus internship or without it, are very much to the fore. As chairman of the Committee on Nursing Education, Miss Hazel Keeler will make a valuable contribution to your understanding of the whole situation in her editorial in May.

The opening sentence of the foreword to a very useful little book "The Nurse Speaks" by Roy C. Nelson, Ph.D., reads: "The changing concepts of the role of the professional nurse in the hospital, in health agencies, in industry, and as a citizen in the community have emphasized the fundamental importance of the great need for increasing experience in the art and science of communication." If the writer had used "public relations" instead of "communication," the program of our national Committee on Public Relations would have been summed up in that one sentence. Miss Ethel Gordon will gave us her account of her committee's activities in the June issue.

* * *

The application of all of our knowledge of people and their minds, in order to prevent mental illness, is the basic theme of a **mental health program.** Such a program strives to prevent or eliminate crippling emotions and attitudes, to re-adjust unhealthy aims and ideals in order to secure for everyone the fullest potentialities for happiness and usefulness.

None of us can choose our ancestors so each comes into the world with a complex inheritance. Over and above our inborn capacities, everything that ever happens to us, everything we do or think or feel, impinges upon or modifies our personalities, and shapes our destiny to a greater or lesser degree. On the positive side, therefore, we must remember that every person needs to feel that he is loved, that he is important to others and to himself; to feel secure in his emotional relationships, self-confident in his social environment. He must learn to face the reality and perils of his physical environment and to adjust to these unhampered by abnormal fears and anxieties.

Unhappily, psychiatric symptoms occur all too frequently in the rush and turmoil of present-day living conditions. When all of our endeavors to assist an individual to maintain good mental health fail, what then? Most of this issue is devoted to the consideration, by various authors, of how best we may serve our fellows in the preservation of mental health. When the lapse occurs we have an equally important function in seeking the restoration of that health.

* * *

Miss HELEN MUSSALLEM has prepared a brief summation of her intensive work in organizing, conducting and reporting on the first authoritative investigation of the status of a few of the schools of nursing in Canada. No full-fledged evaluations leading to accreditation were made or intended. Rather, it was a preliminary to such a broad program.

After reading Miss Mussallem's summary here be sure that you write for a copy of the full report from your own provincial nurses' association. Just in case you forget the street address (foolish thought!) you will find all of the provincial association headquarters listed in the Official Directory on page 287.

A total of more than 1,600,000 Canadians have received one or more free blood transfusions since the Canadian Red Cross service was established in 1947.

SO FRIGHTENED AND PATHETIC— HOLDING A PIECE OF A DOLL

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Manufacturer—Parke, Davis & Co., Ltd., Montreal 9.

NACTON

Indications—For prolonged inhibition of gastric acid secretion in peptic ulcer.

Description—Each scored tablet contains 2 mg. of (1-methyl-2-pyrrolidyl) methyl benzilate methyl methosulfate.

Administration—Usually, one or two 3 times a day and at bedtime.

Manufacturer—Bencard, P.O. Box 99, Weston, Ont.

NARDIL

Indications—Depressive states.

Description—Phenylzine dihydrogen sulfate, tablets 15 mg., monoamine oxidase inhibitor, acting selectively on the brain.

Administration—Initially, one tablet 3 times daily. After maximum benefit has been achieved — usually 2 to 5 weeks — slowly reduce dosage over several weeks to 15 mg. once daily.

Manufacturer—Warner-Chilcott Laboratories, 727 King St. W., Toronto.

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Administration—For ocular therapy, should be applied in the lower conjunctival sac 2 or 4 times daily or as often as every 2 hours. In otic diseases, the same dosage schedule should be followed.

Manufacturer—Lederle Laboratories, 5550 Royalmount Ave., Montreal 16.

OILATUM SOAP

Indications—For diseased skin where a mild soap is indicated. Also indicated for sensitive and dry skin conditions. Excellent for infant use.

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Manufacturer—Stiefel Laboratories Inc., N.Y.

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Description—Each tablet contains: Paraflex (chlorzoxazone) 125 mg., Tylenol (acetaminophen) 300 mg.

Administration—One or two tablets 3 or 4 times daily.

Manufacturer—McNeil Laboratories (Canada) Ltd., 357 College St., Toronto 2B.

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Manufacturer—McNeil Laboratories (Canada) Ltd., 357 College St., Toronto 2B.

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Random Comments

Dear Editor:

In looking over the December issue of the *Journal*, I noted the table of Antidotes on page 1095. I thought it might be of use to bring to your attention the fact that the treatment listed for No. 4, Hydrocarbons, is not recommended by the Poison Control Centre at the Montreal Children's Hospital. As a matter of fact, they are most emphatic that vomiting must not be induced nor the stomach contents aspirated. They recommend instead high liquid intake, and, as soon as hospitalized, chest x-ray, antibiotics and careful observation. Apparently the danger of pneumonia is very great and it is on this that the first aid and medical treatment are based.

E. C., Quebec

Dear Editor:

It was with interest I read the article by Alice C. Mills in the November issue of *The Canadian Nurse*, "The Role of the Nurse Midwife in Great Britain." Since taking a midwifery training at Queen Charlotte's Hospital, London, Eng. in 1937, it has been my regret that Canadian mothers do not have the same maternity service, that all comparable countries have, in the service of a nurse midwife.

The mothers are very safe in the hands of these highly qualified nurses — well trained to deliver a baby when the birth is normal, obtaining prompt medical aid at any signs of abnormalities.

I am looking forward to the time when an article on "The Role of the Nurse Midwife in Canada" appears in *The Canadian Nurse*. Lets have more articles on this important subject.

E. M. H., Ontario

Dear Editor:

Please note the error in the formula on page 24 of the January, 1960 issue in the article "Test Construction in Nursing Education." This should read:

$$L = \frac{80}{9}\left(\frac{x\text{-}m}{\sigma}\right) + \frac{220}{3}$$

Wm. H. Lucow, Manitoba

Dear Editor:

About a year ago, after months of illness in our family, I became depressed and was advised to develop a new hobby. I chose to collect small pieces of silver cutlery from interesting places around the world. I have found the correspondence very interesting but have had a problem finding someone in different countries, for instance Uruguay, who reads and writes English.

I noticed in the December issue of *The Canadian Nurse* in "Between Ourselves" that the *Journal* has subscribers in 103 countries. Could you tell me how I could obtain a list of names and addresses of nurses in these lands. For over a year I have been trying to obtain names of people to whom I could write through our government representatives abroad, missionaries, Rotary Club, and the Friendship Club of England.

Any help will be appreciated.

Mrs. J. L. Ross,
Thornton,
Ontario, Canada.

¶*Perhaps some of our readers in different countries would like to help Mrs. Ross in her search.* Ed.

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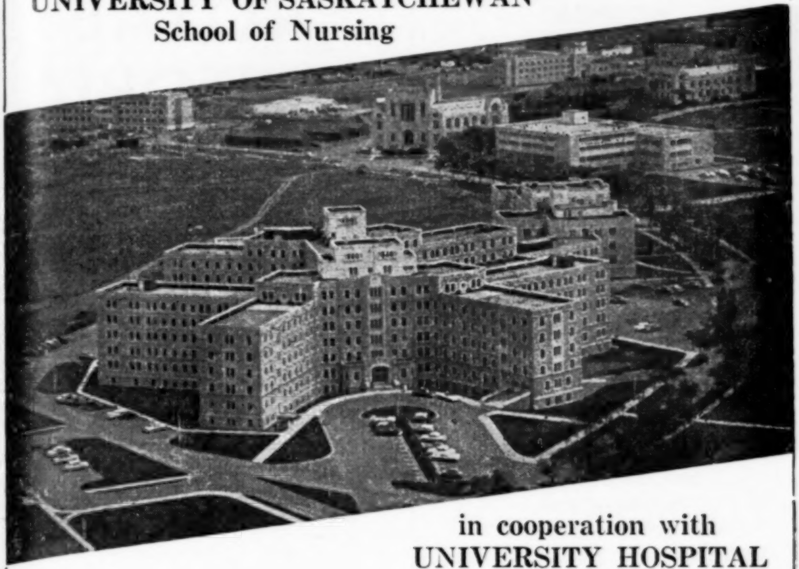

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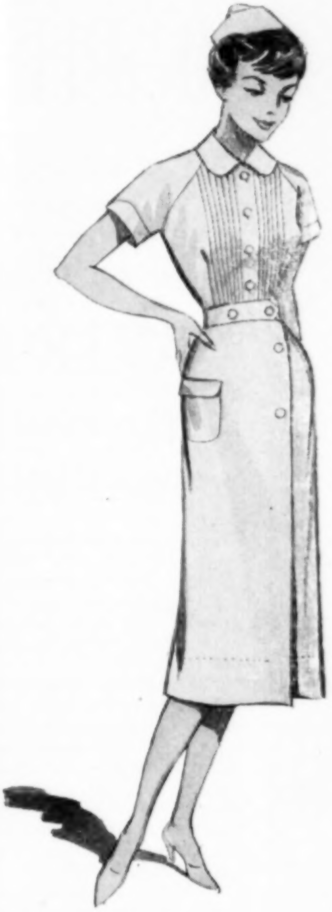

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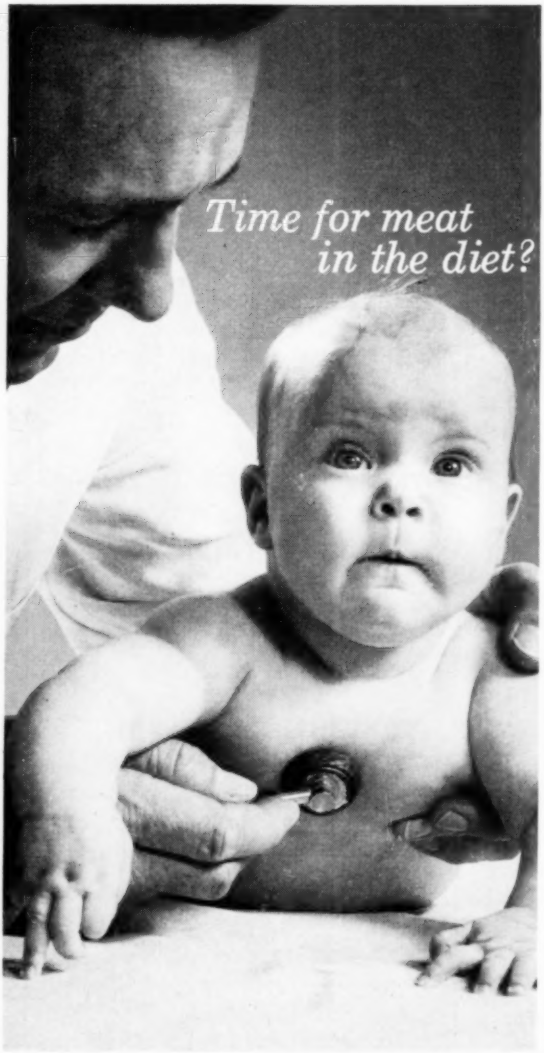
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THE CANADIAN NURSE

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VOLUME 56 NUMBER 3
MONTREAL, MARCH 1960

Hast Thou Faith?

When our President took office she gave us the word "Faith" to be our watchword for the 1958-60 biennium. As we near the end of this period we might ask ourselves a searching question. Have we kept faith, with our profession, our public, and ourselves?

I have adapted my title from the New Testament. In Hebrews, Chapter XI and Verses 1 and 3, we read: "Now faith is the substance of things hoped for, the evidence of things not seen," and "Through faith we understand that the worlds were formed by the word of God." I know of no field of endeavor that surpasses nursing for the extent to which achievements and successes are measured through "the evidence of things not seen."

In the field of hospital nursing service we can cite innumerable instances of patients whose recovery can only be described as miraculous. We attempt to pinpoint the reason for these achievements: improved techniques, higher standards, better qualification, more clearly defined functions, a broadening concept of responsibility. But above and beyond all our efforts we sense and acknowledge an Unseen Power supporting our best though meagre efforts — "things not seen."

We are said to be suffering from a wave of commercialism to the neglect of professional idealism and the mission to serve. We do not accept this

(Wright Studios)

E. A. Electa MacLennan

criticism as valid but we need to look carefully at any of our actions which might have given rise to such a suggestion.

Nursing has experienced a rapid, mushroom growth. This phenomenal growth has brought about many crises of development in innumerable types of situations all at one time so that we have tended to confuse traditional roots with habitual ruts.

As a profession we have endeavored to direct this growth into desirable patterns of professional performance. In the Act of Incorporation of the Canadian Nurses' Association one of the chief objects of the Association is stated: "To dignify the profession of nursing by maintaining and improving the ethical and professional standards of nursing education and service."

The pioneers of modern nursing recognized that if nursing was to survive and develop as a profession fundamentals must be protected, standards determined and maintained. Through legislation, carefully designed and continuously revised to meet changing needs, the nurses of yesterday provided protection to the public from unsafe practices.

We can see many problem areas and acknowledge their grave implications for the future of the profession but with a strong and vigorous profession as our heritage need we fear the future? The General Secretary of the International Council of Nurses has said: "The Past is inspiring, the Future is challenging, the Present is our responsibility." The forward look should be kept. The past is gone except for the lessons it may teach. Neither clocks nor men run backward successfully. The future should be faced with confidence for it promises growth, greater satisfaction and ever-widening opportunities for enjoyment of life and for service to mankind. "Faith is the substance of things hoped for, the evidence of things not seen" and "Through faith we understand that the worlds were formed by the word of God."

HAST *THOU* SUCH FAITH?

E. A. ELECTA MACLENNAN
Second Vice President
Canadian Nurses' Association

The humanities, by their very nature, should enter continually into life at every period. If this could be accomplished, our professional nursing students would approach their life work in such a way that they might realize the larger background significances of living. For the humanities have to do with the living of life, and living the good life can be accomplished only by having as an ideal the most complete possible self-realization as our goal . . . this is a high goal and yet if aims are low, achievements are not likely to be high.

The students in a professional school are experienced in practical affairs. They have a gratifying appreciation of actual values. They know when things are valid and not mere entertainment and idle talk. Students want something of real value, something that will command their respect, something they would be willing to use as guidance in life and able to use as a means of adjusting to their place in our society.

Because the students in a nursing school do not usually go on with other English studies they should be given a rich course in literature from the point of view of scholastic philosophy, with a special emphasis on critical principles. These principles, once mastered, may be applied to any imaginative symbolic structure, whether it be a book, movie, radio or television play.

Literature by the very greatness of its scope and by its interpretive and reflective nature seems to be the chief means of learning about our world and about the men in it. When taught in the "wide and luminous view" of the humanities, literature is seen to be as varied and diversified as life itself. The world of poetry and fiction presents to us the world of human beings . . . this critical study of literature confers a blessing of understanding as well as a lesson in the participation of life.

— CLARA M. SIGGENS

* * *

In the seven years since television started in Canada, Canadians have bought nearly 4,500,000 radio sets — 3,500,000 TV sets were sold in the same period.

— CBC Information Services, Ottawa

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Solvency is entirely a matter of temperament and not of income. — LOGAN SMITH

A Community Mental Health Clinic

F. Grunberg, M.D., D.P.M.

The function of such a community clinic is to serve as an educational factor in the prevention of mental illness and as the medium through which rehabilitation can be continued following discharge from hospital.

Community or social psychiatry is one of the new trends in this medical speciality. We are witnessing at present the development of community psychiatric services all over North America and Europe. In the past two years in Saskatchewan two full-time mental health clinics were established — one in Swift Current, the other in Prince Albert.

Mental illness, more than any other form of illness, elicits very strong societal reactions in the community. The history of these reactions and attitudes runs a parallel course to the history of psychiatry as a medical speciality. It can be divided into four phases:

1. The dark age or the phase of *superstition* during the middle ages in which the mentally ill person was not regarded by society as being sick. He was thought of as a sinner, possessed by the devil and deserving punishment. Developing a mental illness at that time carried very grave risks for one's life.

2. Next came a phase of *custodial care* in which society no longer equated mental illness with crime or sin. However, the community did not look upon the "insane" as an individual suffering from disease in need of treatment and care. He was still considered a threat and nuisance. It was expected that he should be removed to an institution where he would be looked after for the rest of his life. Society did not have any therapeutic expectations from these institutions and the medical profession as a whole paid a minimum of attention to this problem.

3. The *hospital treatment* phase is relatively recent. As medical men realized these people were individuals suffering from a disease that was amenable to treatment, a more humanitarian climate developed. The belief grew that patients admitted to a mental hospital had a right to some form of therapy so that they could go back and find their place in the community. However, a complete break with the past is not easily achieved. Society inherits old prejudices that are very hard to kill. Part of this inheritance was the physical setting and economic philosophy of the custodial care phase with the result that most mental patients are still cared for in huge, monolithic institutions, far removed from their families and communities. True, the cost per day per patient remains lower than his counterpart in the general hospital.

It was during this phase that psychiatry developed as a medical speciality, that the concept of the untrained psychiatric attendant was changed to the utilization of the prepared psychiatric nurse, with treatment and return of the patient to the community as the ultimate objective.

Treating these patients in hospital has increased our knowledge and improved therapeutic methods. We know how to diagnose and treat them from the moment they enter the mental hospital until they leave it. We remain very much in the dark, however, as to what happened to each patient during the weeks, months, years preceding admission. We are very ignorant about what happens to him after his discharge until he is readmitted again. With the present methods of treatment, 80 per cent of our admissions can be discharged with some improvement, but we have to face the fact that over 30 per cent of our total intake are readmissions. We do not know why certain patients have to be readmitted and

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Dr. Grunberg is director of the Mental Health Clinic, Swift Current, Sask. This paper was delivered at the convention of the Saskatchewan Psychiatric Nurses' Association last year.

others do not. It is very probable that we shall never find an answer to this dilemma so long as our philosophy remains patient-hospital centered with complete disregard for the patient-community problems.

We have very detailed and accurate descriptions of the evolution of diseases, such as schizophrenia, manic depressive psychosis, in the mental hospital but we have very little data on how those same illnesses develop and evolve in a non-hospital environment. What is not often recognized is that the mental hospital environment, like most other kinds of hospitals, is very artificial, with little in common with ordinary living in a community. It is artificial at the physical level, at the interpersonal level, yet on the basis of adjustment to that environment we very often decide if a patient should remain in hospital or might return to the community.

A new concept in vogue in some mental hospitals, is known as "milieu therapy." Studies of hospitals that have tried to become therapeutic communities rather than custodial institutions have shown that acute behavior disturbances, withdrawal and regression can be considerably reduced by paying more attention to the interpersonal needs of patients and staff. Unfortunately, very little attention has been paid to the question of whether this experence in the hospital therapeutic community has helped the patient to adjust subsequently in his real community, which is by no means necessarily therapeutic. Milieu therapy has definite positive aspects and is undoubtedly preventing secondary deterioration as a consequence of institutionalization but the fact remains that the large mental hospital, totally divorced from the community that it is supposed to serve, is still only a moment in the course of a mental iilness. Patients begin to be ill long before they enter the hospital and continue to be ill long after they leave it. We do not yet know the full extent of mental illness in the community.

4. This leads us to the fourth phase in the history of psychiatry: the care of the mentally ill *in the community*. I shall discuss the role and the functions of a community mental health clinic in relation to the mental hospital. Let us first examine the situation in an area with no local outpatient psychiatric facilities that is served only by distant psychiatric wards or mental hospital. The community has to rely on its own resources to cope with five types of problems:

(a) The severely disturbed patient whose deviant or aberrant behavior cannot be tolerated by the community. These patients are usually acutely psychotic and are committed to mental hospital by the family physician and sometimes by the courts. Many of them respond to treatment and are able to come back and find their places in society. There are, however, a significant number of patients who, although symptomatically improved when they leave hospital, relapse within weeks or months and are referred back to hospital. A sort of ping-pong game takes place between the expelling community and the receiving mental hospital, causing a great deal of frustration and discouragement to both.

(b) There are the moderately emotionally disturbed people including the neurotics, the so-called inadequate personality. They constitute a free-floating, unhappy population who run from general practitioners to chiropractors, ministers, social workers, friends, seeking desperately for some form of help. Some are undoubtedly helped by the various members of the community but many are running around in circles from frustration to frustration, thereby causing much unhappiness around them.

(c) Creating much concern in a community are the emotionally disturbed children, the "problem families." Doctors, teachers, social workers and others do what they can to cope with a situation that is often beyond their actual resources.

(d) There are the children and adults who are markedly retarded mentally. Teachers of special classes and public health nurses try to cope with the problem. In the long run, the usual result is that these individuals are placed in institutions.

(e) Finally, there is the psychiatric geriatric problem. Last year 37 per cent of the total first admissions to Saskatchewan's two provincial mental hospitals were patients aged 65 or over. About one-third of the geriatric population accommodated in institutions is in mental hospitals. The establishment of a few local nursing homes and sheltered accommodations in the community alleviate to some extent this intractable problem, but the fact remains that the mental hospitals must carry a large share, more than the actual incidence of mental disorders in this age group would justify. Many old folks are sent to mental hospitals because they have nowhere else to go.

These are the main mental health problems that any community has to face. Devoid of local psychiatric facilities, the community tries to cope with the problem in a rather disorganized and uncoordinated way. Hospitalization to a distant mental hospital is often the ultimate outcome. A community mental health clinic moving into such an area does not enter a vacuum but rather a "no man's land" between the community and the distant mental hospital. A strategy has to be adopted within the community itself to avoid duplication of services between doctors, public health nurses, social workers, ministers, who are all working individually and often at cross purposes in trying to meet the need. Furthermore, some pattern has to be developed to establish communication and coordinated efforts between the community and the hospitals. I shall concentrate on this aspect of the problem because this is where nurses are most concerned.

There is a question any nurse must ask herself when a new patient is admitted to her ward: "Why has this man been sent to hospital?" Her only source of information apart from the patient, are the two medical certificates which really tell very little. The patient is very often too ill, too frightened in this strange hospital environment, to give any clear account of what happened so questions remain unanswered. The nurse will, of course, do her utmost to make the patient feel comfortable and help him to adjust to the ward. He will be seen by a psychiatrist, who has no more background information than the nurse. A diagnosis will be made and a course of treatment will be decided. Within two or three weeks, when the patient's treatment is well underway, some relative may travel sometimes hundreds of miles to visit him. Usually this takes place during a weekend when most of the psychiatrists and social workers are off duty so the fundamental questions remain unanswered. The patient will improve, will adjust to the ward routine, will participate in occupational activities and, after a while, everybody will be satisfied that he is ready for discharge because he has made such a good adjustment to the hospital environment.

This patient might have been living in a social setting that could have been conducive to his illness and might need some modifications. His family may expect the hospital treatment to achieve a much more radical change in his personality and will not look at his return in a realistic manner. They might not even want him back. These are all fundamental problems that cannot be answered by only observing the adjustment of the patient on the ward. These questions cannot be dealt with adequately when there is no communication between the hospital and the community. The extremely high readmission rate in most mental hospitals is the well known result.

When the Swift Current Mental Health Clinic was established, I became acutely aware of these problems. I considered that the establishment of communications with the mental hospital and psychiatric wards serving our area was a priority task. Short of local psychiatric in-patient facilities, I decided to develop the clinic program to be an active link between the community and the hospitals and to offer the services that the distant hospitals could not undertake.

One of the primary functions of a community mental health clinic is to screen and prevent the hospitalization of mental patients. It has been noted that most patients become ill long before there is any thought of sending them to hospital. At first, the illness is not recognized as such, either by the patient or by his family. External circumstances, which are no more than ordinary stresses of life, are blamed. The patient will be advised "to pull himself together . . . not to worry . . . to take a holiday."

This temporizing will go on until the whole situation becomes intolerable to the patient and his family. When this happens, the community decides that the patient is mentally ill and that he should be sent to a mental hospital. This illustrates the fact that the social variable is as important as the clinical variable in the hospitalization of a mental patient. A community mental health clinic can, by early diagnosis, intensive outpatient treatment and social manipulation, prevent hospitalization of a mental patient to a distant mental hospital. If, however, the patient has to be admitted to hospital, its staff will be provided with the necessary background information and will be aware of the real issues involved so that the treatment can be conducted logically and comprehensively.

The second important function of a community mental health clinic is the rehabilitation of the discharged or convalescent patient following hospital psychiatric treatment. A word that is often used as a substitute for rehabilitation, and which I find very improper, is "after-care." This implies a very old-fashioned idea that only hospital treatment cares for the mentally ill and that post-discharge attention is something different from treatment and somewhat less important. Thomas A. C. Rennie, a pioneer in social psychiatry states:

> Many years ago a patient reported to me a phrase which illustrated the needs of rehabilitation. Upon his discharge from a psychiatric hospital after months of intensive therapy and restoration to his previous level of mental health functioning, he was advised by his physician: "Now go home and find your niche."

Finding the niche is, in large part, the problem of rehabilitation. The usual treatment process itself gives no guarantee of successful accomplishment of this admonition. As pointed out by Professor Aubrey Lewis:

> Rehabilitation is so much related, in most people's minds, to the hospital inpatient that it is rather difficult to accustom oneself, as I think one must, to the repudiation of any idea that rehabilitation stands for a distinct stage — the post-hospital stage — in the patient's progress back to normal life. I don't believe it does. Treatment must come partly from outside the hospital . . . and must from the outset be guarded and restrained by considerations affecting ultimate resettlement . . . The attempt to distinguish sharply between rehabilitation and treatment seems futile and pointless.

What are then the aims of rehabilitation? They are defined by the National Council on Rehabilitation as "the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable." Personally, I feel that this definition is nothing less than the ultimate and most ambitious aim of treatment.

As far as mental illness is concerned, we unfortunately know very little on how to achieve these goals. A complete and comprehensive plan of psychiatric rehabilitation remains to be devised. It is obvious that the mental hospital totally divorced from community action cannot fulfil this function. There is no question that the rehabilitation of the mentally ill can only take place by work in and with the community. It implies a reorientation of our treatment goals and it is definitely more ambitious than removing a set of symptoms and achieving a good level of adjustment to the hospital ward. It has to start as soon as the patient is admitted to hospital and involves everyone — the psychiatrist, the psychiatric social worker, the therapist and the psychiatric nurse. It is obvious that the mental hospital is handicapped when dealing with patients from distant communities but the community mental health clinic, being "on the spot" can serve as the necessary link. It can and it must point out to the hospital treatment team, the area in the patient's behavior requiring modification for his future resettlement in the community. At the same time, it has to modify the social environment while the patient is in hospital and prepare the community for his return. Upon his discharge, an extensive follow-up program has to be applied, with the aim of providing considerable support to the patient and his family. The first few months following discharge from hospital are very often crucial for the future adjustment of the patient.

In Swift Current, we have attempted to apply these principles by establishing a very close liaison with the psychiatric wards and mental hospital serving our area. We have also tried to obtain the cooperation of the local general practitioners in having their patients screened at the clinic before referral to hospital. The response on the whole has been very good. A large proportion of patients have been seen at the clinic before going to hospital. For all the other cases, the clinic's social worker has made a point of contacting the families shortly after admission and a social history is swiftly forwarded to the hospital. She also visits the mental hospital once a month and holds conferences with the hospital staff regarding the current hospitalized patients from the Health Region.

In brief, the clinic staff works intensively with the families and community while the patient is treated in hospital. Upon discharge, every patient with his family automatically receives an appointment to attend the Mental Health Clinic. If the patient cannot travel, an initial post-discharge home visit is made by the clinic's psychiatric social worker and, if necessary, by the psychiatrist. After this initial assessment, it is decided whether the case should continue to be followed by the clinic or referred to the district public health nurse who will keep the clinic posted on the patient's progress, or early signs of relapse. Of course, the privacy of all patients is respected. A few have refused to maintain contact with the clinic, but those instances are very rare.

This program is still at an early stage and proceeds very empirically. There are, however, some encouraging indications that the readmission rate in the Region is decreasing while the discharge rate is increasing. This strengthens my conviction that psychiatric treatment has to be given at the community level. Coordinated efforts between the mental hospital and the community mental health clinic are not only desirable but a must.

Illness and Applied Psychology

Sister Joseph Ovide, F.C.S.P., M.A.

Here is a searching look at illness. What nurse has not spent, at least a few moments, with like thoughts?

ILLNESS represents a human conflict. One might say that it dates back to the beginning of creation and the departure of man from the Garden of Eden. It is a form of individual conflict, a drama that plays itself out in the human being who has come to grips with illness — an unique experience for each one of us. Sickness then is a form of human and individual conflict that reflects upon the physical and emotional integrity of the person.

According to A. Cuvelier[1] doctor-psychologist, modern occidental man is particularly sensitive to the effects of illness. He accepts the progress of aging and the inevitability of death with great difficulty. The same author maintains that modern man seeks escape from himself and his fundamental, intrinsic spirituality, that he seeks an existence in the lives of others. Withdrawing from his inner self, he becomes the slave of people and things around him and finds his reason for being in collective activity. Looked at in the light of this, illness with its enforced isolation and inactivity can lead to genuine personality disintegration. The subjective impressions of having been crushed and made lesser can awaken feelings of insecurity, frustration, even guilt. These complex feelings will serve to promote emotional conflict.

In the system of emotions, the two poles are anger and fear. Anger induces aggression, attack, movement towards an adversary, while fear makes the individual withdraw into himself.

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There is movement involved in fear as well, but it is one of recoil, with a vague personality break-up. As a result we encounter two behavior types in the emotionally ill. On the one hand there is aggressiveness or a sort of questing as the individual seeks for love and protection. He may even use rudeness, violence or similar measures since they attract attention. In contrast fear tends to result in avoidance of contacts with the individual taking refuge in solitude, daydreaming or even illness.

Fear, anxiety and obsession are manifestations of mental distress. They are defense mechanisms. Through such a mechanism, the patient introduces a point of least resistance into his personality which may be pierced by an outburst of distress as he first becomes conscious of a threat to his ego.

The type and the origin of mental distress varies according to the existing lines of strength of the individual psyche and the diverse conditions affecting the patient emotionally. More precisely, the fundamental types of mental distress — hardship, neglect, mutilation, conscience give rise gradually to more advanced forms. Primary forms are aroused throughout the course of life in situations that involve separation, hardship, illness, abrupt change to a new life. It is as if these situations touched a chord in the confused memory of the individual related to early emotional trauma.

Nervous tension, that brings about the conflict of illness, monopolizes all or part of the emotional resources of the individual. Under the pressure of irrational forces he automatically reacts through the various defence mechanisms. These mechanisms, if unanalyzed and uncontrolled, can cause the patient to regress to an infantile stage. Such regression opposes progress and fosters mental retardation. It hinders full development of the personality. On the other hand, the emotionally well-developed individual puts his reasoning powers into action to help him face reality, analyze its meaning and gain control over it. Defence reactions in this instance are quickly transformed into conscious, reliable, acceptable and objective behavior as the result of reasoning and confidence. In the well-adjusted personality the conflict of illness does not become deeply rooted since it is only a passing phase. The ego, in conformity with the laws of nature, gradually rises again, unified and whole.

The Attitude and the Role of the Nurse

The nurse with the patient must be free from personal conflicts. Her own suffering and failures must be resolved; her anxieties and passions well-controlled. She must be free from egocentrism so that she can accept the patient as he is, believe in his worth as an individual, and in his own estimation of his responsibilities towards himself, and others.

The nurse must possess the following traits in addition:

1. *Emotional maturity:* She must be capable of objectivity. She must be able to meet and accept others as they are. She must help the patient to attain a greater degree of healthy maturity, but without expecting too much from him since illness sometimes weakens the ego.

2. *Sense of values:* The nurse with a true sense of values will never neglect the person for the benefit of technique, spiritual well-being for material well-being.

3. *Self-fulfillment:* The nurse's personal sense of fulfillment is the mark of a personality that has achieved satisfying sublimation of anxieties.

4. *Competence:* The nurse must know how to profit from study and from experience. She must keep an open mind to the discoveries of contemporary psychology. The variety of information and the efforts being made towards correlating it can assist her greatly in understanding her patient and in caring for him. We must remember however that psychology can not explain human nature completely and its theories must not be taken as final certainties. Unquestioning acceptance in this field would be as unfortunate as scorn or indifference. True learning points the road to wisdom, to temperateness and humbleness, and this, in turn, leads to a deeper understanding of the human being.

5. *Prestige:* The nurse needs authority but it should be acquired in recognition of superior ability — the only true source of prestige.

6. *Desirable Attitude:* It is extremely important that the nurse should have a

healthy, objective attitude towards the patient. Recent scientific research by Stoller and Geertsma[2] confirms this and demonstrates most effectively the unfortunate results of negative attitudes in doctor-nurse or nurse-patient relationships. The study was carried out on a group of students in psychiatric medicine. It showed that the students were very much interested in the theory of mental illness but their anxiety increased in proportion to increased responsibility for and contacts with patients. It was then that the doctor-nurse relationship became crucial and tended to produce emotional responses inappropriate both professionally and scientifically. Subjective reactions composed of anxiety, negative attitudes, rejection and blame prompted the student to *judge* rather than *evaluate* the patient's condition. Their projection mechanisms prevented objective, positive thinking.

The nurse's basic attitude, then, is of prime importance. It is developed out of respect for human worth. More specifically, in the face of agressive behavior, she must avoid an aggressive response since the patient is really seeking understanding. In this respect demands may be made upon her to which she obviously cannot accede in order to avoid an over-emotional attitude on the part of the patient that may emphasize his tendency to regress.

When the patient's attitude is one of withdrawal from reality, the nurse must avoid showing coldness or indifference in order not to intensify this. She will see to it that the patient is kept in touch with everyday events, that he is on good terms with his family and friends. This serves to build up his feeling of security. A sincere interest in the patient, an accurate estimation of his worth as a person and tolerance of his tyrannical behavior will most often be the best response and most effective remedy against feelings of frustration.

To what source can the nurse look for help in developing this ideal attitude, this genuine unselfishness and true poise? Valuable as psychology may be, it can not replace the spirit of true love in accepting and serving our patients. This is the only possible answer.

Reference

1. *The Journal of Medical Education*, Vol. 33, No. 8, p. 585, 1958.

We all wish to be loved alone . . . Mutuality is the essence of love. There cannot be others in mutuality. It is only in the time-sense that it is wrong. It is when we desire *continuity* of being loved alone that we go wrong. For not only do we insist on believing romantically in the "one-and-only" love, mate, mother . . . we wish the "one-and-only" to be permanent, ever-present and continuous . . . There are just one-and-only moments. To return to them, even if temporarily, is valid.

The pure relationship is limited in space and in time. In its essence it implies exclusion. It excludes the rest of life, other relationships, other sides of personality, other responsibilities, other possibilities in the future. It excludes growth . . . One learns to accept the fact that no permanent return is possible to an old form of relationship: and more deeply still, that there is no holding of a relationship to a single form . . . Because it is not lasting, let us not fall into the cynic's trap and call it an illusion. Duration is not a test of true or false. Validity need have no relation to time, to duration, to continuity. It is on another plane, judged by other standards. It relates to the actual moment in time and place. What is actual is actual only for one time and only for one place.

— *Gift from the Sea,*
ANNE MORROW LINDBERGH

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Such truth as opposeth no man's profit or pleasure is to all men welcome. —HOBBES

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The Canadian Red Cross will have to collect 500,000 bottles of blood in 1960 to meet transfusion therapy demands of Canadian hospitals.

The Child is Mentally Retarded

Hero de Groot, M.D. *and* Breg de Groot

This is the story of parents, by parents — for nurses. It is the story of their problem and how they are coping with it. They are not alone with it nor did they cope with it alone.

In 1947 we became the very proud parents of twin boys. We already had a girl, almost three years old and you can imagine how happy we were with those two little babies!

As is the custom in Holland the children were born at home. Only when the doctor expects complications is the delivery done in a hospital. We did not expect any complications. We were even completely unaware of the fact that two babies were on their way instead of one. The boys arrived one month too soon and were rather small, one five pounds, the other only three. There was no nurse; no time to put the kettle on the stove. We did the delivery ourselves, then called on the neighbors for assistance. We telephoned for a taxi so that the smaller baby could go to the hospital to be put into an incubator.

When all these details had been looked after we settled down and enjoyed a good laugh. In this light-hearted way began the biggest "thing" in our lives. Two days later the smaller boy developed such severe convulsions that no one expected him to live. When he did recover it was obvious that he would not be normal, that his brain had been severely damaged. How retarded he would be we could not know.

What helped us most during the first difficult days was that everyone accepted our little boy as just another baby. It was a great moment when the matron of the hospital in which we worked entered the room with a huge basket full of baby clothes, food and flowers. She, like everyone else, considered the event a very happy one and had come to rejoice with us. We did not sit down to discuss what would happen to him eventually; how mentally handicapped he would be. Nobody mentioned the fact that at some time we might have to put him in an institution. In short, we did not try to live his entire life and foresee all future problems at once. He was our child, just like the other two — to love, to cherish, to feed and to keep clean.

This is the point at which the doctor and nurse can be of much support to the parents. It is a deep sorrow for all parents when they have a child who will never leave the parental home to start a life of his own and to continue on the road on which they have given him a start. On the contrary, his life is the end of the road. For him, many of the dreams we normally have for our children will not come true.

In realizing this, parents tend to feel that their own world has come to an end. They do not know how to cope with all of the many problems they foresee. They want to solve them all at once. The nurse can do for them what the matron and many others did for us. She can reassure the parents that they do not have to solve all of these problems at once. They can give their baby what he needs at this moment.

This does not mean that we should never sit down to discuss a long range program for the child who has special needs, but it need not be done right at birth. The nurse can do so much for the parents to help them to feel at ease with their child. Through the nurse's attitude parents receive fresh courage to give this child all of their love, strength and wisdom so that he too may grow up to live as useful a life as he is capable of doing; to do his share of the work of the world, a very

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Dr. de Groot is a practising physician and surgeon in Regina. Mrs. de Groot, was engaged in social welfare in Holland. She has had to overcome many obstacles in order to establish the Harrow de Groot School for Retarded Children in Regina.

modest share maybe, but a necessary one. Whatever the future holds for him does not change the fact that he is, right now, only a baby with the same needs as all other babies. He may not be very strong physically; he may need a different kind of formula and all kinds of special care. Our little boy was completely encased in a cast for a year so that his back would grow straight. In most cases the care is such that parents are capable of giving it and should be encouraged to do so because the child is entitled to it. We have no patience with those who advise parents of a Mongolian child, for instance, to send him to an institution as soon as possible after birth so that they will not become too attached to him. As if attachment had not started nine months before!

As doctors and nurses it is our job to fight disease — to "do something about it." We try to cure. Acceptance without fight is foreign to our nature. Although we have to accept this child the way he is, we do *not* have to accept the fact that so many children are born or become mentally handicapped. Because we do not accept this fact, more and more research is done. Parents who are unsatisfied with the lack of educational and recreational facilities for their children get together and "do something" about it.

The acceptance of the child the way he is, with his limitations and his possibilities, brings with it the acceptance of all the many difficulties that will occur as he grows up, for example, the type of school for their child and his later years spent, perhaps, in an institution. When the child does not make progress in school, some parents are convinced that he does not want to work. They need to be helped to accept the fact that it is not a lack of will but rather that the child cannot do the work. So often the parents of a retarded child force him into the harness of behavior and abilities of an average child, force him toward achievements of which he is not capable, thus doing irreparable harm to his development. The only way to further the development of the child is to allow him to grow up under the most favorable and most suitable circumstances in other words — allow him to *grow up along his own lines*.

Although retarded children have many different needs, they have one that they share with all mankind — to be wanted and to be loved the way they are. We older, more sophisticated people learn to accept the fact that we may be loved for the accessories we have acquired through life — wealth, position, etc. These children do not realize this and they feel rejected. There are many forms of rejection and this hurts them more than anything else.

Although she is not trained to deal fully with this great problem, the nurse can be of assistance in her contact with parents. She can help them to overcome false shame. She can point out what can be done. She can inform them of how they may obtain professional assistance. Only after very extensive examinations have been carried out can a suitable course be planned for the child.

Some parents are not content with the point of view of one doctor and have the tendency to "shop around" for other opinions. This is often frowned upon by the medical profession. However, in many cases it helps the parents to adjust themselves slowly. As long as it does not ruin them financially, it is one means of easing their consciences because many parents struggle with feelings of guilt. The sooner the parents are able to accept the fact that this child will develop at a much slower rate than other children and will need special guidance, the better it is for the child. It is not for us to condemn parents for what appears to be a lack of confidence in their doctors. We should support them and help them to find security in the judgment of their medical and other advisers.

There are many books, pamphlets, films, etc. in which parents, teachers, nurses and others can find extensive information on all aspects of retardation. There are also many excellent books on home training, for example, "You and Your Retarded Child" by Dr. S. Kirk.

The nurse herself needs to be aware of what is being done for retarded children in her own community and elsewhere. There exists in Canada a national association for retarded children which has provincial and local chapters. In Saskatchewan, for instance, the provincial Association for Retarded Children organizes seminars for parents of retarded children who live in rural areas of the province. This provides an excellent opportunity for parents to become better acquainted with the facts of retardation, to observe different techniques and last, but not least, to meet other parents who are facing the same problems.

Earlier in this article it was mentioned that we do not readily accept the fact that so many children are born mentally retarded or become retarded. Most of the research on mental retardation is done in the field of medicine. The program is extensive. More and more, the importance of keeping detailed prenatal and obstetrical records is stressed. This is a field in which the nurse can be of great assistance. The United States Public Health Service is undertaking a five-year study of 40,000 pregnant women in an effort to find the cause of cerebral palsy, mental retardation and other birth injuries. Although so much still needs to be done progress is being made.

A specific type of mental deficiency, that is usually severe and is called "phenylpyruvic oligophrenia" (phenylketonuria, P.K.U.) is diagnosed by a simple paperstrip test (Phenistix). This mental condition is associated with a metabolic error that, recent studies have shown, can be corrected by a restricted diet. Most of the children whose diagnosis is made early and who are placed on a special diet within the first two years of life, improve and show more or less normal development. In order to diagnose this metabolic disorder before the harm is done, many hospitals and well-baby clinics now include this very simple urine test routinely in their examinations.

This is just one of many new developments and must serve as an example of how important it is to be aware and up-to-date, so that human suffering can be prevented.

In the Good Old Days

((*The Canadian Nurse,* MARCH, 1920)

Caring for the Sick Poor

In spite of the remarkable development of hospitals and training schools, there has been constantly before us an unsolved problem in nursing which is becoming more pressing each year — that of providing care in the homes of the poor and the people of moderate means.

The real difficulty lies in the fact that our government system is faulty in so far as it relates to the care of the poor and the sick . . . It is not a system of justice — the majority of our charitable organizations and hospitals must be maintained by private philanthropy.

Is it not possible that the answer lies in organization and inauguration of a system of home nursing on a large scale, which recognizes the trained nurse of present high standards, or even higher, as an essential factor, and supplements her by the employment of experienced assistants and household workers?

This idea has been tried with conspicuous success in several cities, notably Detroit . . . The hospitals are always available and desirable for those who are seriously ill. This system, carried out on a large scale adequate to the size of the problem, seems at the present time to be the best solution.

* * *

Registration of Graduate Nurses

Another province has been able to get legal recognition of the profession by succeeding in passing an Act for the Registration of Graduate Nurses. Quebec is the latest to get this . . . Now all Canada, with the exception of Ontario, Nova Scotia and Prince Edward Island, has an opportunity to standardize their schools and to insure the public that when they employ a registered nurse, she has had a proper training and should be capable of good work.

Years of love have been forgot in the hatred of a minute. — EDGAR ALLAN POE

* * *

Worry, the interest paid by those who borrow trouble. — GEORGE W. LYON

Mental Health and Maternity Care

ESTHER J. ROBERTSON, M.A.

A new life is on its way! How this person-to-be will develop is influenced physically and emotionally months before he makes his debut. Nurses are one of the most important of the influencing factors. How do we meet the challenge?

GOOD maternity care means more than medical and nursing services which have as their objective a live mother and baby. It means services planned to promote the physical, mental and emotional well-being of mother, baby and family. Scientific research and refinements in maternity care have reduced many of the physical risks involved in child-bearing. When adequate medical services and facilities for obstetrical care are available, the modern mother usually ends her pregnancy in good physical health. This is an important objective but it is not enough unless good mental and emotional health are also included. How may we as nurses help the mother complete her pregnancy with confidence and satisfaction as well as with safety? Are we providing her with the care, the information and the type of support she needs?

Fortunately within recent years, the mental health of the mother has been given more consideration. There is increasing recognition of the fact that mental and emotional reactions to childbearing and motherhood may influence the physical course and outcome of the pregnancy. What the mother thinks and feels has a great deal of significance for nursing during the maternity cycle. The birth of a child is one of the events of life that can be described as trying. Pregnancy creates stress. It may become

> a crisis for those individuals who by personality, previous experience or other factors in the present situation are especially vulnerable to this stress and whose emotional resources are taxed beyond their usual adaptive forces.[5]

The mother's ability to adjust to her pregnancy and its stresses, and the way in which she adjusts will depend upon the understanding support she receives from her family and the type of maternity care she receives. As we work with the mother, the family and the doctor, we have the responsibility of contributing to the mental health of the mother and her family. In order to do so we need to be aware of the total health needs of the mother.

> Factors operating on the biological plane in the expectant mother interact reciprocally with factors in her psychological functioning and in the interpersonal relationships of her family group.[2]

The Prenatal Period

Although pregnancy is a normal physiological function, individual mothers vary in their reactions to it. Our knowledge of the normal reactions that are likely to occur will help us to interpret them to the mother and family. Most mothers have ambivalent feelings when they know they are pregnant. She may vacillate between happiness and unhappiness, be depressed or elated. Mood changes are to be expected as she contemplates the responsibilities of motherhood and wonders about her ability to meet them. As her body reacts to the changes in hormone balance, so do her thoughts and feelings, especially during the early part of pregnancy. She thinks of her loss of freedom, of possible changes in her relationships with her husband, of sharing his love with a child. She thinks of expenses involved for her own care as well as for equipment and supplies for the care of the baby. She thinks of the process of labor, often with fear and anxiety.

On the other hand, the mother may think with pride of the ultimate fulfillment of her female role — the bear-

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ing of a child. However, despite her periods of joy and pride, she may be difficult to get along with since she finds it hard to understand her own mixed feelings and reactions. Because she cannot understand herself, she thinks that others fail to understand her. It is not unusual for a prospective mother to experience inexplicable periods of sensitivity and irritability. Her feelings may be easily hurt, her temper short.

As pregnancy advances the mother's thoughts become introspective. She may become demanding of affection and attention from her husband and family. Caplan$_2$ explains this reaction as the possible need of the mother to increase her supplies of love and affection so that later she will be able to pass them on to the baby.

Throughout pregnancy the mother thinks of her own safety and that of her baby. Most mothers build up tensions, anxieties and fears with which they need assistance. All mothers have impressions, ideas and attitudes about childbirth that are related to their cultural, social and educational backgrounds. They have heard accounts of childbirth experiences. Mothers, like all human beings, fear the unknown. By encouraging them to express their thoughts and feelings, by listening carefully and by providing them with information as the need arises, we are able to promote good mental health. The mother who has a knowledge of physiology and the process of labor is more able to overcome her doubts, fears and anxieties as the end of her pregnancy approaches.

To illustrate these normal reactions to pregnancy let us consider Mrs. Barton, an attractive, 20-year-old primipara. She had been married three years and was six months pregnant. Her maternity care was being provided through the outpatient service of a large urban hospital. She appeared shy and reserved on first acquaintance and had difficulty in sharing her thoughts and feelings with anyone other than her husband and a younger sister. Knowledge of her fears, anxieties and attitudes toward pregnancy was gained first from her husband and later directly from her.

Mrs. Barton's sister had had two children, both by Caesarean section. She was therefore unable to share the experience of a normal labor and delivery and Mrs. Barton was too shy to admit her lack of understanding. She said she was "prepared to stand the pain when the time came." Because of her attitude Mr. Barton felt that his wife did not want to have a baby. He thought that she felt "trapped" and because of this was not a bit like her usual, happy self. Some days she said she was looking forward to having a child, on other days she was sorry she was pregnant.

In time Mrs. Barton was able to talk more freely about her pregnancy to the clinic staff. It became apparent that she wanted to have a family. The warmth of tone in her voice when she discussed her small niece and nephew implied that she loved children and wanted a baby of her own. Basically, she feared labor and separation from her husband. When she learned that he could be with her in the labor room, she became less apprehensive. As she began to understand the meaning of labor and the physiological process involved she became interested in the simple breathing exercises and positions of relaxation that she could use. Together, she and her husband planned for their baby with confidence and understanding.

The support and encouragement of her husband is important to the prospective mother's adjustment and to her mental and emotional health. If she is secure in her husband's love, she is more likely to think of her coming baby with pleasure and eager anticipation. She is able to think of motherhood with a more realistic approach as her confidence in her own ability and her trust in those providing her care develops.

The Nurse's Role

The nurse is in a position to help parents plan for the coming baby. She provides the background information to ensure that the birth of their baby may be anticipated with confidence. She assists them in avoiding some of the tensions, strains and frustrations of daily living by helping them to understand the physical changes that are taking place in the mother, her need for rest and an adequate diet. The nurse may guide and encourage parents toward independent action as they work out plans and make decisions related to their needs.

There are some mothers who need *special* help during the prenatal period. These include the unmarried mother, the mother who has lost her husband through death or separation after conception, and the mother whose attempts at abortion have failed. The mental health of these mothers may be in a precarious position. The counselling skills and abilities of the nurse are of utmost importance. The nurse can make a worthy contribution if she is free from prejudiced personal opinions; if she listens carefully and tries to think through the situation from the other person's point of view; if she refrains from prying and probing; and finally, if she can recognize when a problem is beyond her scope. Then she can assist the mother to obtain the help of a specialist.

Many of these mothers have complex social problems. Often, they fail to seek medical care and need help in obtaining it. Team work between doctor, nurse and social worker is essential so that support, understanding and scientific information become available to the mothers. They have the same basic need for reassurance through relief of doubts, fears and anxieties as all pregnant women. Their special problems make their adjustment more difficult. An adequate discussion of the nurse's role in providing maternity care for mothers with these special problems, would require separate detailed consideration, but the basic principles for promoting mental health through information, understanding and support are the same for the maternity care of all mothers.

Labor and Delivery

The mother who has had the opportunity to express her thoughts, her doubts and fears; who has had her questions answered; who has received information to prepare her for labor and delivery should enter hospital with no more apprehension than anyone has in a new situation. She is in a strange environment that is symbolic of illness. She is not ill but rather has come to hospital to fulfil a normal physiological function. Her thoughts centre around her baby and her ability to deliver it. She expects help and support. She tries to remember what she has learned about labor and what she is expected to do.

From the moment the mother enters the hospital, the nurse has a supportive role to play. She has an opportunity to meet the mother's mental and emotional needs, while she attends to her physical needs. Explaining procedures, informing the mother of her progress, helping her to relax, encouraging her and answering her questions are some of the ways in which the nurse may contribute to mental and emotional well-being. In some hospitals the husband who wishes to do so, is encouraged to remain with his wife in the labor room. The nurse is in a position to help them make it a satisfying experience. A husband is able to provide support if he knows the role he is to play and if he feels secure in it.

As labor progresses the mother become very dependent on the doctor or nurse for the kind of support that will ensure a satisfactory experience for her. With the newer philosophy of obstetrical care, more mothers are able to participate with conscious effort during the final stage of labor and delivery. Care should be taken that comments and discussions are interpreted to the mother so that she understands. Unnecessary mental anguish may be caused by thoughtless remarks.

Conscientious planning by the nurse is necessary to safeguard the mother's dignity, to preserve her modesty and to reduce her feelings of dependency as much as possible. Supportive care means care provided by

> an understanding nurse — a nurse who asks herself, what would I want if I were in this woman's place? — and then does what her judgment tells her she herself would want. This is empathy — *experiencing with* — as contrasted with sympathy — *feeling for*.[4]

Following Delivery

Immediately following delivery the mother will want to see her baby. Often the first look at the newborn is a shock for which the mother needs to be prepared. During pregnancy she has thought a great deal about her baby. In all probability she has formed a mental image of what he or she will look like. Even if she has been told what a newborn does look like, she may still be disappointed. She needs to know that his unsightly appearance is temporary.

The mother may think of her baby as a stranger and find it difficult to establish a relationship with him. During pregnancy she may have thought of him as part of her body, something unseen. In her state of fatigue following delivery or early in the postpartum period she may again experience an overwhelming fear of the responsibilities of motherhood. There may be a feeling of rejection of the baby when she thinks about the burden and cost of care and the sacrifice of personal freedom.[7] She needs help with her adjustment to her baby and to a new way of life. Aware of her own disappointment in the baby's appearance she may wonder how her husband will feel when he first sees it. Future parent-child relationships may depend upon the understanding support the nurse is able to give to the young parents as they become accustomed to the new member of their family.

Parents whose baby is born with a congenital malformation, require a very special type of professional assistance, support and counselling. The nurse's role is influenced by the severity of the malformation, the doctor's relationship with the parents and the role he plans to play. The parents, doctor and nurse work together to plan for the future of the baby and family.

Getting to Know the Baby

During the postpartum period the nurse will anticipate and then help the mother to cope with the "letdown feeling" that is likely to occur. The mother may be disappointed in her "motherly feelings" and find them different from what she thought they would be. The nurse may discuss with her the fact that maternal love is something to be learned.

> 'Maternal instinct' develops with encouragement and with experience as the mother learns to care for her child. Assisting the mother to develop competence and confidence in her ability to care for her child helps her to become independent and to face reality.[6]

Where rooming-in is provided, the the mother is able to have her baby in the room with her for most of the day. She has an opportunity, with the help of the nurse, to become better acquainted with him. She learns his habits and gains satisfaction from participating in his care and in making him comfortable and content. The father too has an opportunity for closer relationships with mother and child. Gowned and masked, he may handle the baby and get accustomed to him. Often, the father is the one who gives the mother the special type of support and encouragement that she needs so badly as she is learning to love her baby. The parent-child relationship fostered under these circumstances contributes to the future good mental health of the whole family.

The choice of a method of feeding the baby may be a point of conflict for many parents. During the prenatal period the mother may decide whether or not to breast feed. If she does decide to breast feed, she will need considerable support and encouragement as she and the baby learn the technique involved. Successful breast feeding fosters strong identification between mother and child and helps promote the feeling of "motherliness." On the other hand, failure in the attempt to breast feed causes feelings of inferiority, discouragement or guilt. Whatever the method of feeding, the mother's feelings affect the baby. If the baby fails to gain satisfaction from his feeding experience, both mother and baby become tense and anxious. If the feeding experience gives satisfaction, the baby and mother interact with harmony.[1] Nurses are in a position to provide the information and assistance needed to make the feeding experience a satisfactory one.

Taking the Baby Home

As the nurse helps the parents prepare to take the baby home, it is well for her to remember that there is no *one* way of caring for a baby.

New parents often think that their inexperience will harm their child. They do not know that love rather than skill counts. Helping them to understand that their baby will respond to their love and care with a sense of trust and a feeling of security will reassure them. Parents need to know that this basic trust and security is the foundation for their child's future good mental health.

The degree to which parents can provide the material things of life varies with economic circumstances, but, family relationships that build and promote a healthy type of family life may be achieved in any home. There is no price tag on love, trust, respect and faith nor on parental guidance, as the child learns to take his place within the family group. These are the essential ingredients of good mental health. Adult mental health is based on childhood experiences. There are no limits to the contribution that a skillful, understanding nurse may make through the maternity care she provides. The opportunities are many and varied. It is our responsibility to recognize and use them with wisdom and skill.

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The Public Health Nurse and Mental Hygiene

NOREEN PHILPOTT

Is the concept of public health synonymous with physical health? If it is not, then does the present application of this concept include promotion of mental health and prevention of mental illness?

HAVING passed through the heroic era of medicine with its haphazard methods of diagnosis and treatment, through the anatomic age when the mysteries of the human body were first revealed, and through the era of bacteria initiated by Lister's theories on asepsis, we have now reached what may be termed "The Age of the Psyche."

Psychiatry has become recognized as a science in itself while the treatment of the mental as well as the physical manifestations of illness has developed into the study of psychosomatic medicine. Going back in history, we see that the search for a treatment of a disease usually far preceded the search for a way to prevent it. Today, the prevention of mental illness is one of the foremost subjects of concern. In spite of the increase in the numbers of patients discharged per year, our psychiatric hospitals continue to plead for larger quarters. The flow of drug addicts, emotionally disturbed individuals and those who are mentally retarded appears unending. This has emphasized the need to seek the causes for these deviations from the normal and has necessitated the formulation of certain criteria for mental health. To some, the criterion would be merely an absence of mental disease. This is comparable to the description of wealth as being the absence of poverty. Mental health must be an optimum state composed of factors which contribute to and maintain a truly balanced personality in the individual in society.

What are these factors? The first is an understanding and acceptance of "self" — the physical, emotional, and intellectual states. This implies living within the limits imposed by one's body while endeavoring to main-

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tain good physical health. *Mens sana in corpore sano.*

The acceptance of the emotions of joy and pride does not entail the difficulties that often ensue when one attempts to reject or ignore the more unsavory feelings of guilt or hatred. The latter may result in the utilization of mental defence mechanisms. We rationalize our behavior to try to exclude these expressions of inner turmoil from the conscious mind. When such attempts become too frequent or too extreme, the balance essential to optimum mental health is disturbed. This disruption of the personality equilibrium may affect not only the emotional patterns but also the entire philosophy of life of the individual.

Just as our emotions deeply affect our actions so do our thoughts and attitudes. This must be recognized and accepted if we are to see ourselves as we are and so become capable of honest criticism of our emotional well-being. We also need recognition and acceptance of intellectual ability. To judge one's innate capabilities by the results of an intelligence test or an academic examination is not sufficient. The endowed powers of accomplishment are rarely utilized to their fullest and are too often channelled in inappropriate directions. One should strive to learn his own limitations and work to the best of his ability.

The second factor is the acceptance of others — not with mere tolerance but with the sincere desire to understand them. This is essential to man who, as a social being, exists not alone but with others and develops his own personality, at least in part, through interaction with others. To truly accept someone else as he is, one must first be conscious of one's own emotions and attitudes and realize that others are capable of experiencing the same problems, aspirations and failures as oneself.

Finally, one must have a philosophy of life based on a belief in something other than himself — a Supreme Being, a way of life. The form which it takes is individual but the need for such a belief is universal. To exist *by* one's self *for* one's self is impossible. Man alone is too frail a foundation upon which to build personal security. The goals that we set are not the most important consideration. It is the manner in which we strive toward them that is of consequence. The Bible shows us the way to be acceptable in God's sight; the ideals of democracy demonstrate the path to freedom; the ethical code of a profession gives its followers the instruments with which to gain an acceptance and an understanding of the true meaning of success in that field. Thus, to believe in something which we ourselves are not but which we plausibly could be is important in attaining the balance between success and failure — a balance so essential to mental health.

What is the responsibility of the nurse in the field of mental health? She must cultivate healthful attitudes toward her own emotions and actions and also toward those exhibited by others. Once she can recognize and honestly accept the concept of mental health, she may then act in her capacity as a teacher to help others to attain it. Do our schools of nursing fully prepare the fledgling nurse for her responsibility in this sphere? The instructor who does not realize the need for giving support to the shy student who finds it difficult to talk with her superiors is not exhibiting good mental health techniques. The young girl who has been relatively sheltered in her own family group and who is suddenly faced with the responsibility of caring for critically ill patients, may undergo undue emotional stress. An outlet should be given, such as a general discussion of such feelings in the classroom. To learn that she is exhibiting a normal reaction to the situation is of definite importance. Where does the student learn this? Are nursing students taught that each new situation which confronts them contributes to the growth of their minds by aiding them to develop a mature outlook on life?

The factor of maturity has entered into this discourse and clarification of the term is necessary. In this context, it is the ability of the individual to attain the highest possible degree of mental health; to live compatibly with himself as well as with others; to accept the responsibility for his own decisions and actions; to contribute according to his abilities to the betterment of society. These attributes are essential to the girl who seeks to be a truly capable nurse. The attainment of maturity does not occur in the early growing years. It may be attained only by the concentrated effort of the individual.

In public health nursing, more emphasis is placed upon the prevention of disease and the education of the public than in other branches of nursing. Thus, it is in the community that the nurse must place more stress on the subject of mental health since it can be accomplished more effectively here than in the hospital. Is she well-equipped for such teaching? Psychiatric affiliation has not yet been made compulsory in all basic nursing courses in Canada but we are progressing to this point. Perhaps the future will bring not only classes in mental pathology, but also a good basic course in mental health. This will come about only through the individual efforts of all those who are concerned with nursing education. For the present we must rely solely on what her past experiences will contribute to the individual public health nurse's ability in the field of mental health.

What about inservice education in mental health for the staff of public health agencies? Here, the greatest immediate stumbling block may be found. When the subject is presented protests follow. The schedule is already crowded and it is not the agency's duty to undertake the preventive aspects of psychiatry! Another objection is that the agency does not have the staff available to provide such teaching for other personnel. The crux of this whole matter appears to be that our civilization has parcelled itself into too many specialized spheres each of which balks at the idea of trespassing into the other's field. The general hospital is basically for the care, treatment, and education of the physically ill person. The bulk of health education and the prevention of illness falls to the public health agencies. What is overlooked is that our psychiatric hospitals are equipped only for the care of the mentally disturbed individual. They are not equipped to promote the mental health of the population at large.

In order that public health workers may become aware of their responsibilities for mental health, an inservice educational program is definitely required. We must first indicate the need for such a program and then provide the qualified personnel to carry it out. To provide a starting point psychiatric social workers could discuss the aims of psychiatric rehabilitation. By using an illustration of a situation to which a former patient must return and with which he must resocialize one of the reasons for educating the public could be pinpointed. Once interest has been aroused, the program could be enlarged to include practical applications of theoretical speculation. Talks could be given at meetings of community workers where each group could decide on its own method of resolving the problem. Another method is group discussion at staff meetings in order to formulate a plan for incorporating mental health into the overall public health orientation of new staff members.

Once it has been established that the promotion of mental hygiene is the responsibility of all who are interested in the health of the community, the workers must be given the opportunity to make practical applications. One means could be through the development of a specific program such as the provision of home care for psychiatric patients after discharge from hospital. Any family that has undergone the stress of a long-term illness needs assistance. Following mental illness the stress is increased by the stigma that still surrounds it. Only by public education can this adverse badge be removed. Teaching must begin within the family. The attitudes in the home must be evaluated, the illness described and explained so that it is regarded as the same as a physical disability. The help of the family can be enlisted to aid in the general rehabilitation of the patient. Later both patient and family will need the support of the nurse as the patient returns to his job, his church and his social life. The minister, the employer, the friends of the patient must all be shown how they can help. In the course of dealing with the problems of one psychiatric patient, the public health personnel may find that they need to educate the community at large. Thus through close teamwork between psychiatric workers, public health agencies and the public, an appreciable step forward could be made in the field of mental health.

These examples illustrate the practical application of mental health techniques in the rehabilitation of the emotionally disturbed. However, mental health is not solely the absence of mental disease. How may the other aspects of mental hygiene be promoted in the over-all program of a public health agency? A prenatal visit that includes instruction in the essentials of nutrition and exercise should also consider the emotional adaptation of the body. The mother-to-be can be encouraged to express any fears or doubts that may arise. She can be helped to adapt to the new state of parenthood. She must feel that she can turn to the public health nurse for constructive help in developing a healthy attitude toward her own future and that of her family.

The preschool and school age child is in the process of developing the basic traits and mental outlook that will have a profound influence on his adult personality. The parent who vents his feelings on the child, the teacher who punishes a student unreasonably for inattentiveness are not instilling a good concept of mental health. The public health nurse who has contact with the child, his parents, his teachers and his schoolmates needs the knowledge and techniques that can promote the growth of the child into a healthy adult. She must be able to work with both parents and teachers to help them to see and to solve the difficulties that arise either in the home or in the school. She should give them the opportunity to express their observations of the child and provide them with guidance in dealing with specific situations. In this way she promotes not only the mental health of the child but also that of the adults with whom he is in contact. The result will be the gratification of seeing healthy, happy children develop into healthy, mature adults.

It is recognized that health agencies cover a much broader field than has been indicated here. By using prenatal care, psychiatric rehabilitation and schoolwork as examples, the integration of mental health into the public health field is more easily understood. The public health nurse is not alone in her efforts to promote mental health. She is part of a team. Social workers, physicians, educationalists and other public figures are all working with her in their respective fields. The nurse, however, can integrate mental health promotion into her work of maintaining good physical health. She can help the others on the team to play their parts. Education alone will not produce the desired attitudes. There must be acceptance by the general public of the need for assistance and guidance along these lines and a willingness to practise good habits of mental as well as physical health.

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A wasted skill, a misapplied ability is a threat to the capacity of a free people to survive. A society must learn to regard every instance of misuse of talent as an injustice to the individual and an injury to itself.

— *Pursuit of Excellence: Education and the Future of America*

The Management of Crisis in Human Situations

Mary F. McHugh, B.N.

What is a crisis? When, why and how do crises develop? How does a nurse's ability to perceive impending crisis effect her behavior?

Why is the concept of crisis a useful one from the point of view of the nurse? What can the nurse gain from an understanding of this concept? If one accepts the theory that all those present in a crisis situation affect responses to the crisis and the subsequent behavior, one can readily appreciate that an understanding of crisis is of vital concern to the nurse. She is part of any crisis situation in which she finds herself. The more understanding she has of how crisis develops, the better able she should be to help prevent crisis. Some crises, however, are inevitable. In such instances the understanding nurse can lend support to others involved in the situation.

Let us consider crisis as an event which disturbs the equilibrium of social relationships in a situation. My purpose is to indicate how this concept may be useful in both nursing practice and nursing education. My comments will be confined to a discussion of four factors that influence both the development of crisis in human situations and the response of the individuals.

1. The stage of life at which the event occurs.
2. The unique personalities of these individuals involved in the event.
3. The varying backgrounds of experience of individuals.
4. The values they hold.

The Stage of Life

The timing of an event may determine whether or not it is a crisis. For example, for a two-year-old the experience of going to hospital can very readily constitute a crisis in the life of that child, as John Bowlby$_1$ has shown. Rene Spitz$_4$ has indicated that the personality development of children may be severely impaired if, at critical ages, they are separated from their mothers. The film, "A Two-Year-Old Goes to Hospital," illustrates the significance of the young child's separation from his mother.

For a fourteen-year-old, a period of hospitalization would be much less likely to develop into a crisis. He can be prepared for the event. He can be helped to understand the purpose of surgery and something of the circumstances under which it takes place. Friends and relatives of such a patient take these events in their stride. They know his distress will be short-lived and that he will soon return home. The disturbance to his social equilibrium will be minimal.

Whether or not an event constitutes a crisis in the life of an individual then, is determined in part by the time of life at which the event occurs. The nurse who understands this concept may use her understanding to guide her own action and that of others in human crisis situations.

Individual Personalities

Birth, death, and serious illness are commonly accepted as crisis situations. We are less able to accept the possibility that crisis may be inherent in the transition from one phase of life to another and yet research findings substantiate this notion.

Eric Lindemann$_3$ and his associates in their study of community health found that the transition from a high school to a hospital school of nursing presented considerable hazards for vulnerable persons. The researchers' findings indicated that for some students the frustrations were severe enough to be considered a life crisis. The stu-

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Miss McHugh who was clinical instructor in the operating room of the Montreal General Hospital, now works in Western Canada. This paper was presented as part of a symposium on "The Management of Crisis in Human Situations" at the American College of Surgeons Convention, Nurses' Section, held in Montreal during 1959.

dents' expectations of nursing were very different from the real situation. Added to this was the grief that resulted from leaving family and home. These factors, along with the anxieties stimulated by the relative intimacy of living together in a residential program and the confusion resulting from comparisons between the ideal role of the nurse and the actual nurse behavior encountered, temporarily destroyed their equilibrium.

If we ourselves have not experienced some of these reactions in the transition from a high school to a professional school, most likely we have observed them in others. Some student nurses can take this transition in their stride. Others experience varying degrees of difficulty and for some the crisis is one that they can resolve only by leaving. This concept has implications not only for nursing educators but for all members of the helping professions. Whether or not an event constitutes a crisis in the life of an individual is determined, in part, by his unique personality.

Background and Experience

What has gone before in a person's life influences his perception of a present situation and the way in which he responds to it. Two people with similar illnesses who are faced with the prospect of hospitalization and surgical treatment may respond quite differently. Their different responses are due, in a large measure, to earlier experiences. All of us are familiar with the patient who feels at home when he comes to the hospital, who knows what is expected of him and who feels that he will be looked after. He feels secure in the presence of those to whom his care is entrusted because his previous experiences with hospitals have been satisfactory.

We might contrast this patient's response to hospital admission with that of the patient who comes to the hospital for the first time. He does *not* know what is expected of him nor what to expect of the many strangers around him. Unsure of what will happen to him, he may be most anxious and apprehensive. Admission to hospital has a particular meaning for this patient. Unless appropriate measures are taken to relieve his anxiety, it may well increase. When those who are caring for the patient appreciate the meaning of his emotional response, they are better able to alleviate his excessive anxiety and to prevent it from influencing the course of his illness or interfering with the effectiveness of his treatment.

A crisis may develop for those persons whose past experience makes a specific situation especially meaningful emotionally. Health workers who understand this concept should be prepared to anticipate the development of a crisis situation and, through their understanding, function in the way most likely to relieve tensions and prevent crisis.

Individual Values

Whether or not an event becomes a crisis situation for an individual is influenced by the values the individual holds. These have a specific function. They are the bonds that hold the personality together and give it direction. On the social and cultural level widely shared values perform the same function for the group. The fundamental things in which people believe determine in a large measure the way that they see situations and the manner in which they respond. Individuals, families, other institutions, professions and communities all have their unique value systems. It is possible that few conflicts would arise if values were coordinated and consistent. However, this is not life. At all levels, values tend to be imperfectly coordinated and their inconsistencies contribute to the development of tensions within and between people. If these tensions become sufficiently severe, crises will arise.

Inconsistencies in values can be demonstrated in any profession but perhaps such inconsistencies are most evident in a developing profession such as nursing. As hospitals increased in size and complexity specialization occurred. Enrolment in schools of nursing increased and the trend to separate nursing education from nursing administration developed. In some instances, nursing leaders in hospitals tended to form two groups whose interests and skills were developed primarily in the area of either nursing education or nursing administration.

Although the ultimate goal of both groups was the same — patient care — the way in which one group perceived the situation tended to deny the value of the other group's viewpoint. The teacher saw the ward as a place where the educational needs of the students might be met. The head nurse saw it as a situation demanding a given amount and quality of nursing service. Neither one would deny the importance of the other's interests but in this instance the head nurse's values would be largely at one end of a *continuum* and the teacher's values at the other. Such situations create tensions which can be relieved only when values are coordinated.

Most nurses will agree that we have only begun to recognize this problem in nursing and to take steps towards its solution. Through understanding and working together we may be able to prevent the crisis situations which arise out of uncoordinated values within the profession. We could then direct the energy we now use in such situations toward the development of our profession.

Summary

We have considered crisis in human situations. We have implied that an event, of itself, does not constitute a crisis. Rather the degree to which the event disturbs the equilibrium of social relationships determines whether or not a crisis develops. We believe that the ability to perceive impending crisis can be developed and that most crises can be prevented or at least minimized by those who, because they are aware of the factors involved, can respond effectively.

The assistance of Mrs. Helen Gemeroy, assistant professor of psychiatric nursing, McGill University, Montreal is gratefully acknowledged.

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3. Lindemann, E.: The Meaning of Crisis in Individual and Family Living. *Teachers College Record,* p. 314, February 1956.

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As nurses, we do not diagnose or recommend medications, but there is nothing to prevent us, legally, from recommending a good book. Nor would we be doing any patient a disservice by knowing something about books and current reading materials. Some patients need only to be led to the realm of books to be introduced to a whole new world. Some need to be reminded that books exist, and some — far too many — will need to be guided to a proper choice of reading.

Nursing Outlook, November, 1959

* * *

Injustice is relatively easy to bear; what stings is justice. — H. L. MENCKEN

* * *

All of us are becoming more price conscious, more aware of the shrinking value of the shopping dollar. The monthly cost of living index reported by the Dominion Bureau of Statistics used to show the monthly figure with the values in 1939 as the basis for comparison. After the figure so obtained had sky-rocketed, the comparative figures were based on the level in 1949.

With some nostalgic yearnings for the "good old days" of 1939, here are some comparisons of interest to every wage-earner. The 1959 figures are based on prices in Montreal in December, 1959.

Item	*1939*	*1959*
Milk (quart)	$ .10	$ .23
Bread (24 oz. loaf)	.10	.22
Butter (lb.)	.31	.65
Coffee (lb.)	.25	.99
Calves' liver (lb.)	.48	1.45
Round Steak (lb.)	.30	.98
Bus ride	.08	.20
Cigarettes (20)	.25	.40
Medium-size car	1,000.00	2,800.00
Small house	4,500.00	10,000.00
Subscription to *The Canadian Nurse*		
Through fees		2.00
Personal	2.00	3.00

NURSING across the NATION

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION, OTTAWA

Hospital Insurance and the CNA

In November, 1959, the CNA presented a submission to the Advisory Committee on Hospital Insurance for the organization and financing of hospital schools of nursing.

The CNA, recognizing the large sums of money which are presently being spent for schools of nursing and expressing grateful appreciation of this, advocated that:

> The monies available and to be assigned to nursing educational programs in hospital schools of nursing be
> 1. reserved and used to enhance the educational calibre of the program
> 2. administered by those directly responsible for the educational program of the school.

The CNA advocated that the school be regarded as an autonomous educational institution, in this instance, having the right and responsibility to control the student's entire experience — academic and clinical — in the interests of that student's professional preparation as a nurse.

CNA Sub-committee on Finance

A meeting of the Sub-committee on Finance was held at National Office on December 19, 1959. It was recommended that a Sub-committee on Investments be formed. The terms of reference of CNA loans were reviewed. The two criteria for granting of loans still stand —

1. that the applicant be a member of the CNA
2. that the money would be used for advanced preparation.

Mental Health Institute

The Dalhousie University School of Nursing held a three-day institute on Nursing Aspects in the Mental Health Program February 24 - 26, 1960 in the auditorium, Victoria General Hospital.

Miss Peggy Pike, head of the Psychiatric Nursing Research Department of Allan Memorial Institute, Montreal, was the conference leader, ably assisted by Dr. Robert O. Jones, professor of Psychiatry, Dalhousie University, and other specialists in this field.

The CNA Retirement Plan

The Canadian Nurses' Association Retirement Plan is actually two plans in one — "A" and "B". Plan "A" is designed for nurses who are self-employed or are employed where no employer contributions are available and who must therefore rely on their own savings to provide for retirement. Plan "B" is designed for nurses who are working for an employer who will join with them in setting aside money for their retirement.

Within each plan there are two funds in which the nurse may place her contributions — the Insured Annuity Fund and the Common Stock Fund.

In the Insured Annuity Fund, the pension you buy is determined precisely at the time you join the plan according to your age and the amount that you save. This may be increased by the dividends credited to you by the insurance company during the time that you are saving for retirement.

Under the Common Stock Fund, your contributions are invested in a well-balanced portfolio of common stocks of leading corporations. Your share in the Fund is sold when you retire and the proceeds are applied to purchase a pension at that time. The amount of pension that is then bought will depend on the market value of common stocks at that time.

All members of the Canadian Nurses' Association who have not attained the age of 70 may join Plan "A", the personal plan, or Plan "B", the employer-employee plan, (within the terms set by the employer) of the Canadian Nurses' Association Retirement Plan.

A Review of the Pilot Project

HELEN MUSSALLEM, M.A.

Getting ready for such a far-reaching development as the evaluation and accreditation of schools of nursing requires comprehensive preliminary studies.

THE Pilot Project for Evaluation of Schools of Nursing has been completed. The report of this study which will be available to all members of the Canadian Nurses' Association is in the process of being published. The recommendations made as a result of this study have been reviewed by the Executive Committee of the Canadian Nurses' Association. During the project, information on each step appeared in "Nursing Across the Nation." A brief sketch of the total project will bring everyone up to date.

For many years, the Canadian Nurses' Association had considered the feasibility of initiating a program of accreditation for schools of nursing in Canada. At the general meeting in 1956, the Association approved a resolution to study all aspects of such a program. This decision was motivated by the belief that if the quality of nursing service rendered by the profession was to be improved, then preparation for that service must be improved. It was also recognized that nursing, as any other profession, had a responsibility for evaluating its own program of education.

Purposes of the Project

Following the general meeting, the purposes of and a plan of action for a Pilot Project for Evaluation of Schools of Nursing were formulated by a special committee. These purposes were:

1. To determine whether Canadian schools of nursing are ready for a program of accreditation and, if it is feasible at this time, to initiate a program of accreditation.
2. To determine the basis on which schools of nursing in Canada can be accredited.
3. To explore procedures for carrying out an accreditation program.
4. To determine the personnel and other resources needed to carry out a national program of accreditation.
5. To estimate the cost of a national program of accreditation.
6. To acquaint the Canadian people with the needs of nursing.

Selection of Schools and Visitors

In order to obtain the necessary data, each of the 174 diploma schools was invited to indicate willingness to participate. Ninety-six schools volunteered. From this group the special committee for the Pilot Project selected 25 on the bases of geographical location, size, control and type of program. At least one school in each province was chosen. Two schools were selected in each of the four Western Provinces, five in Ontario, seven in Quebec (five of these were French language schools), and five in the Atlantic provinces. The committee also named ten regional visitors to participate in the surveys of the schools, and one senior bilingual evaluator.

Orientation of the Director

A director for the study was ap-

Miss Mussallem took leave of absence from her post as associate director of the school of nursing at Vancouver General Hospital in 1957 to become director of the Pilot Project.

pointed in September, 1957. In preparation for her responsibilities in directing the Pilot Project the director worked with the National League for Nursing Accrediting Service for four months, studying the philosophy and procedure of their program with a view to adapting these methods in the survey of selected schools of nursing in Canada. This orientation included participation in accreditation visits in widely distributed geographical areas in the United States. It was a most interesting and stimulating experience. One could not but be impressed by the dynamic nature of their program.

The policies, criteria and procedures followed in the American accreditation program in nursing are based on principles widely accepted and tested in education for the other professions, and in general education. Accreditation in nursing is more than an evaluation. It is a program in which the educational units themselves play a vital part. It aims to help schools in their efforts to improve the nursing program they offer by providing them with assistance in the continuous process of self-evaluation. The impression gained was that voluntary national accreditation could be a most effective means of encouraging schools of nursing to improve their programs.

Preliminary Visits

In initiating the Pilot Project, it was decided that prior to the full week survey, a preliminary visit should be made to each participating school. Accordingly, a one-day visit was made by the director to each of the selected schools in order to acquaint the faculty and administration with the survey procedures and to explain the types of suppplementary data required.

Interpretation of the Project

Activities carried on during the preliminary visits and surveys of schools of nursing included conferences with provincial deputy ministers of health, and with national executive directors of organizations. Interviews were also arranged with the national Deputy Minister of Health and other national representatives interested in the Project. Addresses were given, on request, to such groups as provincial registered nurses' association meetings, hospital association meetings. Workshops were conducted on the evaluation of schools of nursing.

Press releases were sent from National Office during the preliminary visits, and the majority of the local papers printed the information. Because of a decision of the CNA Executive not to publicize the names of the schools being visited, newspaper publicity for the full survey visit was left to the school concerned. In areas where the schools released this information, it was encouraging to note the coverage given. Several press interviews were held, as well as interviews on radio and television.

Following a recommendation from the National Committee on Nursing Education, a communication was sent to the provincial executive secretaries, indicating that the regional visitors were prepared to interpret the project in their area, and many requests for this were filled. Other means used to keep people informed included: memos sent out from time to time to schools participating in the Project, magazine articles, report to the Joint Committee on Nursing, etc.

The Survey of the Schools

A one-week survey visit was made to each selected school of nursing during the latter part of 1958 and up to April, 1959. The purpose of the visit was to validate and clarify the written material describing the program, as well as to assist the faculty of the school in identifying their own problem areas and to develop skills in seeking solutions to these problems.

The survey team consisted of the director of the project and one regional visitor from a neighboring province. The regional visitors were all nurses well qualified for this role both by experience and personality. In the visits to the French-language schools, Sister Denise Lefebvre, who has given great leadership throughout the entire Project, acted as the senior bilingual evaluator. The survey teams were fact-finders; they did not evaluate the program.

The Visits

Each visit was a stimulating and exciting experience. The visitors were impressed by the very favorable reaction of the directors of the schools and in fact the entire staff of each hospital. No effort was spared to make all required information available. Their keen interest in the evaluation process, and their warm hospitality went far beyond what was anticipated.

The visit to each school was planned to take six days. Monday was used to study all the written materials describing the program. These materials included the questionnaire which was 69 pages in length and took most schools three to four months to complete, and 21 additional items such as: the Minutes of all meetings, copies of all rotation plans in use, a copy of the articles of incorporation or other evidence guaranteeing the legal right of the hospital to operate a school, copies of all contracts with cooperating agencies, a complete set of all course outlines, etc. The next three days constituted the actual visit. Each evening and all day Friday the visitors were busy writing the report. Saturday morning the report was read to the members of the staff. Saturday afternoon any necessary corrections to the report were made. Sunday the visitors travelled to the next school. Each survey required approximately 65 working hours.

Writing the Survey Report

When the data had been verified, the visitors wrote a report on the program. With two visitors on the fact-finding survey team, a more exact and unbiased report could be written. The report described the program; it did not evaluate it. Each survey report was typed at National Office and sent to the director of the school for further correction. When it was returned to National Office, the report was stencilled and sent to members of the Board of Review for evaluation. This rather lengthy procedure ensured that the school's reports used as the basis of the data analyzed in the Report of the Pilot Project was accurate.

The Board of Review

The prescribed procedure provided for a board composed of ten members who would study each survey report and pass judgment on the educational program of the school surveyed. Eight board members were nurses representing all the types of programs being evaluated. There was also one representative from the Canadian Medical Association and one from the Canadian Hospital Association. The board met twice; once in October, 1958 for orientation and the review of five survey reports with a final meeting in May, 1959 for evaluation of the remaining schools. The decisions made by this group on the status of the schools are included in the final report.

Evaluation by the Participants

To assist in the evaluation of the techniques used in the Project, the schools were asked to evaluate this entire process. The guide questions were:

1. What have you liked in this evaluation procedure? (strengths)
2. What areas in the procedure might be improved? (weaknesses)
3. What suggestion for change in procedure would you recommend?
4. After having participated in this survey of the Pilot Project, do you believe the Accreditation of Schools of Nursing in Canada would be desirable? Why?
5. Other comments.

The responses were not most encouraging. Some of them appear in an Appendix of the final report. A fairly typical response of the reaction to the total project is summarized from comments made by one of the directors of nursing whose school was visited:

> The Evaluation Program is a means of helping schools raise their standards. It is neither a loss of time nor a waste of money. On the contrary, it helps schools of nursing to keep pace with modern progress.
>
> Having participated in the Pilot Project, our vision has been considerably lengthened. We are more acutely aware of our shortcomings than ever before. People do a better job when they know what they are supposed to do, when they understand what authority they have, when they realize what constitutes a job well done in terms of scientific results, and when they are aware that what they are doing is of value.
>
> The visit made to our school by the survey team has given the teaching body, the administrative personnel — in fact our entire staff a more adequate sense of direction.

The Decision on the Project

The report on the Project has been completed and recommendations have been made. This report will be distributed by each provincial nurses' association to the members for study prior to the biennial convention. It is at this meeting that the membership will decide, in the light of this study, on the best course to be followed in order to maintain better nursing service through better nursing education.

The Psychiatric Nurse as an Observer

ELISABETH RATKOWITSCH

The psychiatric nurse's ability in the role of observer can make a significant contribution to the patient's recovery. Is the need for keen observation confined to psychiatric nursing? How can nurses become therapeutic observers?

EVERYONE observes people. The primary motives are either idle curiosity or a basic desire to understand others. Most psychiatric nurses possess a cultivated curiosity and an eagerness to understand. Observing patients is one of their chief roles and it should be done with a sincere interest in and desire to serve the patient. A certain degree of curiosity is doubtless essential. To be merely curious about a patient is certainly not desirable. It must not be forgotten that mentally ill patients are human beings and not inanimate objects.

More and more a psychiatric nurse is expected to be a keen observer and to record and report her observations. Each contact with the patient is an opportunity to observe: to find out how he can be helped, what he is saying with his behavior, what he needs, what kinds of experiences he requires. With this approach it is possible to note and to communicate observations and to use them in determining how to help the patient to foster his own emotional growth.

As a participant observer the nurse scrutinizes not only the patient's behavior, but also her own. She studies responses and learns how to use her relationship constructively. It is very important for her to become aware of her own feelings toward the patient and of how the patient views her. Naturally, there are limitations in her ability to recognize what is going on. Therefore, a collaborative relationship with the psychiatrists, psychologists and other members of the health team is essential. Harry Stuck Sullivan states:

> Whatever the techniques employed for observation of human behavior, including verbal report of subjective appearance, it is important to note that the act of observation is itself human behavior and involves the observer's experience . . . When it comes to the matter of perceiving another person, not only is there the object and the perception of the emanations from the other person, but also the distorting, confusing and complicating factor of our past experience with other people who looked like this, who sounded like this, etc. In other words, it is fabulously more complicated than is the case with non-personal reality.

To make keen and objective observations is a complex task. Some nurses have a natural ability, others gain it by training and experience, some will never possess it. Objectivity means truth in what we observe and in personal insight. To be objective is not a simple matter. Most members of a nursing staff will admit that their

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A graduate nurse from Graz, Austria, Miss Ratkowitsch was on the staff of Victoria General Hospital, Winnipeg, before going to the Allan Memorial Institute, Montreal, for postgraduate study in psychiatric nursing.

observations are not always objective. They get twisted either by personal feelings or by misinterpretation. Few nurses deny never being subjective.

Factors in Ability to Observe

1. The personality of the nurse
2. Her past experience, skills, educational background
3. Her age
4. Her interest in the patient
5. Her physical well-being
6. Her relationship with the patient's doctor
7. Her flexibility.

It can be easily understood that the personality of the nurse affects her observations. How many times does a hostile nurse report or chart that patients are hostile? She projects her own hostile feelings. To perceive hostility in someone else is to avoid perceiving it in oneself. There is the depressed, downcast nurse. She seems to see things more darkly than they exist; the patient's condition appears to her to be poor or hopeless. There is the fearful nurse. She is blocked from seeing the patient's anxiety and insecurity. The more preoccupied she becomes with her own fear, the less able she is to see how frightened the sick person is and to find ways of relieving his fear. A selfish nurse, who cannot bear it when a patient prefers another staff member, will seldom have a positive statement about this patient. If only all nurses could understand that many unpleasant experiences such as rejection, attack, suspicion and disrespect cannot be taken personally. Nurses have to keep their balance, accepting objectively the opposite experiences of admiration, praise, dependence, etc.

It also seems to be very difficult to be objective when the nurse is too emotionally involved. There can be no personal relationship without emotional involvement, but it should not be overdone. When it is, there is a tendency to see the patient's behavior as more acceptable and better than it really is. The actual situation will be overlooked and the patient will be protected whenever possible. The less training and experience the nurse has, the easier it seems to be to become involved. The older, experienced nurse is more alert. It is not unusual to hear a young student nurse say about a very sick, but good-looking man: "Oh! he is most charming, so marvelous and interesting. I can't see anything wrong." She probably will not report that the patient was slightly intoxicated when downtown. Instead she charts that he went to a movie, then to bed on his return.

Psychiatric patients as well as all other sick persons often become too dependent on the staff. They like to be babied and are requesting a relationship so close and so filled with love that a nurse never can satisfy them. When they become active and are well again they are equally anxious to drop this relationship. A few nurses find this hard to understand since a dependent or "sticky" patient fulfils some of their own neurotic needs.

The ideal psychiatric nurse is a happy, sensitive person who has outside interests and who feels that she can accomplish much in her work. She becomes less emotionally involved and sees things more accurately. There seems to be a relationship between the ability to observe and the level of insight that a nurse may have.

Accepting an awareness of our conscious behavior is a difficult problem. It can hurt to recognize and to admit personal problems. Everyone has them — psychiatric nurses are no exception. Being a New Canadian and having spoken English for only two years, I hesitated at first to chart that a foreign patient's command of English was poor and difficult to understand. I identified myself with him and felt that if I put this down I would be confessing my own lack of knowledge of English. I had to force myself to write the facts.

Observations can be influenced by the relationship between the nurse and the patient's doctor. For example, examine the following nurses' comments:

> We don't bother sometimes to report to a hostile doctor.
>
> If we get support from the individual doctor, we are more interested in making accurate observations.
>
> If I dislike a doctor, I make less careful observations.
>
> If the intern works alone, I am less on my toes.

Sometimes there appears to be a lack of collaboration between the nurses and the newly arrived intern. Many of these inexperienced young psychiatrists show resentment at being dependent upon nurses' observations. They very seldom ask a nurse about a patient and do not like to be told how a patient is behaving. They depend almost entirely on their own observations — studying the patient for a short time each day. As the intern becomes more experienced he becomes more tolerant of the nurses and begins to realize how much their observations can contribute.

Staff doctors as a rule are more interested in nurses' observations. A few of them read them and combine the intern's notes with the nurses' reports in the weekly progress notes. Most doctors consider that the nurses' observations are very important and valuable. They realize that she is the one who observes the patient over a 24-hour period, who sees him when he is far from being at his best. She is with him during all moods, through all phases, at mealtime, at ward activities and with his visitors. She observes his appearance, attitude, mood, appetite, activity, reaction to routine and his sleeping habits.

Nurses have expressed the idea that psychiatrists fear that they may interfere with psychotherapy or attempt to interview and interpret. The doctors I questioned did not see any danger of interference with psychotherapy. The opinions expressed about interpretation were all much the same. It was generally felt that nurses' interpretations are unreliable because different nurses will interpret in different ways. It must also be remembered that the doctors receive reports from nurses at different levels of experience: student nurses, postgraduate students and graduates. Doctors prefer a description that is expressed in good but simple English without interpretation and without psychiatric terminology.

Medical researchers are an exception. They expect observations on a different level. For example, the nurse observes that a patient spends hours and hours in front of the mirror. To the researcher she can report that the patient is *narcissistic*. In another instance, the nurse notes that a little man eats enormously. He asks for two bowls of porridge at breakfast, six pieces of toast, drinks four cups of coffee, is very talkative throughout the day and likes smoking. The researcher is the only one who will be pleased to hear that this patient's *oral needs are increased*. Other psychiatrists prefer to get the full description. The nurse must describe in detail what she sees and hears and not what she *thinks* the patient is doing or how she *thinks* he is behaving.

There are varying opinions as to whether or not it is training and experience that make intelligent observers. Some doctors and nurses think that this ability definitely depends on training; that the important symptoms have to be pointed out first so that they can be recognized and noted. Others feel that training is not as important. They recalled untrained personnel who had made very good observations and had been more sensitive to patients' needs than some nurses with training in psychiatry. Certain nurses can receive a good training, become theoretically excellent, but be of little use to patients because they lack understanding and warmth.

It is a difficult task and takes time and effort to become a good psychiatric nurse. Formerly, in the general hospitals where nurses trained or worked, nursing care was categorized and not too much emphasis was placed on treating the patient as a total individual. The sick person was treated according to his diagnosis which was related to an illness or bodily function. Too often his emotional needs were overlooked. It was not recognized that the illness and all that it implies were most important to him and that he reflected this in his moods. Many patients become very anxious and self-centered.

In psychiatry, a diagnosis is mainly important for its use in research and statistics. The mentally ill person is treated according to his individual needs. Differences in his needs are related to his personality as a whole. The nurse brings many skills to this new field, but she has to relearn them and develop new powers. Her personality, mind and ability to be a good observer of human behavior are more important now. The hands and feet suddenly have not much to do. With them alone, little can be accomplished.

> A patient spent hours drawing a picture of his favorite nurse. He gave much attention to little details, but he gave the nurse no hands. The art instructor reminded him that they were missing and that the nurse certainly needed them. But he answered in a firm voice: "They are absolutely unimportant. She is not using them. All she does is talk with us."

He was quite right. The nurse never brought him medications, never touched him, but spent her time talking to him. She was trying to foster his trust and confidence in people and to make his life worthwhile again.

Most new nurses in a psychiatric unit are surprised to find themselves among patients who are ambulatory and who are people not unlike themselves. Outwardly they differ only in the display of their emotions and the way in which they solve their problems. Many of them are very intelligent. At first, is it often difficult to know what to look for and what is significant. Many small things are not taken for granted in psychiatry. It is important when a patient who has never initiated conversation suddenly starts to talk with somebody or when an untidy patient starts to take pride in his personal appearance and shaves for the first time. The gross behavior changes can be observed without much effort. A child can recognize anger when dishes are thrown around, but to recognize minute changes in behavior calls for alert personnel.

It is uncomfortable at first to sit down and talk or play with the patients. Many nurses are afraid of saying the wrong thing. They do not know what to expect from the mentally sick. It is hard to understand that psychiatric nurses do not play cards or checkers for their own amusement or to pass the time, but that this has therapeutic value for the patient and gives the nurse a good opportunity to observe him. Most patients feel uncomfortable if a nurse sits quietly watching them. She must first learn to gain their confidence, show interest and be considerate. The nurse should avoid interviewing patients too quickly. A patient was once asked too many questions in a relatively short time in an attempt by a nurse to find out how he spent his day. She had spent very little time with him and had no information for report. This sensitive man remarked:

> Nurse, you are not really interested in my welfare. You have only a professional curiosity and have come to check, so that you know what to write down on the nurses' notes.

The more experienced the nurse becomes, the less time she requires to make valuable observations. Some nurses know more by being with a patient five minutes than others would in a few hours. It is similar to people who are familiar with a city. They will find their way around in less time.

Nurses often find it difficult to observe a quiet patient. The majority seem to know more about someone who is outgoing or an exhibitionist. Reports on him are usually of better quality and quantity. The quiet person has the fewest and least informative nurses' notes. His name is more likely to be left out in staff discussions. Most nurses know very little about him. They record the same things every day — that he is not mixing or socializing, occupies time poorly, etc. The nurse has to realize that this patient is withdrawn and isolated and not an introvert or a bore. He needs help and understanding. As soon as she becomes curious and interested, the patient suddenly becomes more alive to her. She notices more details about him.

By careful observation of the withdrawn patient the nurse will be surprised at how many things can be observed. These observations are never a waste of time or boring. A patient tells many things through his silence, but a nurse has to learn to understand non-verbal communications. She can observe his body movements, his facial expression, his eyes, his posture and positions. She also must be astute to subtle hints that such a patient is ready for contact. A relatively minor action can mean a big step to the patient. He expects the nurse to note it. Another positive example of keen observation and intervention occurs when a nurse recognizes that a patient is contemplating suicide. The risk should never be minimized and mounting tensions must be noted.

Summary

Being an observer is one of the

major roles of the psychiatric nurse. She can observe most effectively as a participant. She must observe herself, know her own abilities and difficulties, be introspective. Good observations should be objective, but there are many factors influencing them. For most nurses, it is impossible to be completely objective because of personal feelings and various temperaments. Nurses need support and help from the other team members in order to function most effectively. They must learn to control themselves and should never stop growing emotionally.

A good nurse is sensitive to what her patient needs and what he feels. All of her observations are an intermediate link between patient and doctor and have a therapeutic function.

Reactions to Visitors in a Psychiatric Unit

BARBARA H. NELSON

Modern psychiatry recognizes that relatives are important members of the team which endeavors to assist a patient to return to health. The questions that then arise are: who visits, when, how often and for how long?

The Purpose

The purpose of the study was to consider the question of visiting in a psychiatric unit with respect to:

1. The effect visitors have on patients,
2. the doctors' and nurses' attitudes toward visitors,
3. the effect visiting hours have on the activities which have been organized for the patients.

Not too many years ago, mental illness was considered to be a social disgrace. Accordingly, the person was put away in a mental institution and promptly forgotten. At this time, an ideal relative could be described by hospital authorities as a person who appeared with the patient on admission, gave a complete and accurate history, and then disappeared, except for paying the bill . . . by mail. Relatives were often blamed, consciously or unconsciously, for the illness of the patient, by staff and patient alike.

Through recent advances in psychiatric medicine, it has been recognized that relatives do play an important role in the return of the patient to a normal way of living.

The Setting

This study was undertaken at the Allan Memorial Institute, an open 125-bed psychiatric unit. The institute, is part of the Royal Victoria Hospital of Montreal.

In considering the question of visiting in this psychiatric unit we are dealing with the organization and function of a unit which has as its objectives: the care of the mentally ill person, the advancement of psychiatry through research, and the teaching of personnel involved in psychiatric care. We are also caring for someone who comes from a family and a place in the community. It is the individual patient who will make for many variables in this study. The type of illness the patient has, plus his personal life, will affect the answers that are obtained.

The visiting hours at the Allan Memorial Institute have recently been approved as follows: there are visiting periods three afternoons and seven evenings a week.

At the time of the extension, the assistant administrator of the hospital was interviewed in regard to the reasons for the change. The following reasons were given:

Miss Nelson, a graduate from Saint John General Hospital, undertook this study while she was a postgraduate student in the Psychiatric Nursing Course at the Allan Memorial Institute, Montreal.

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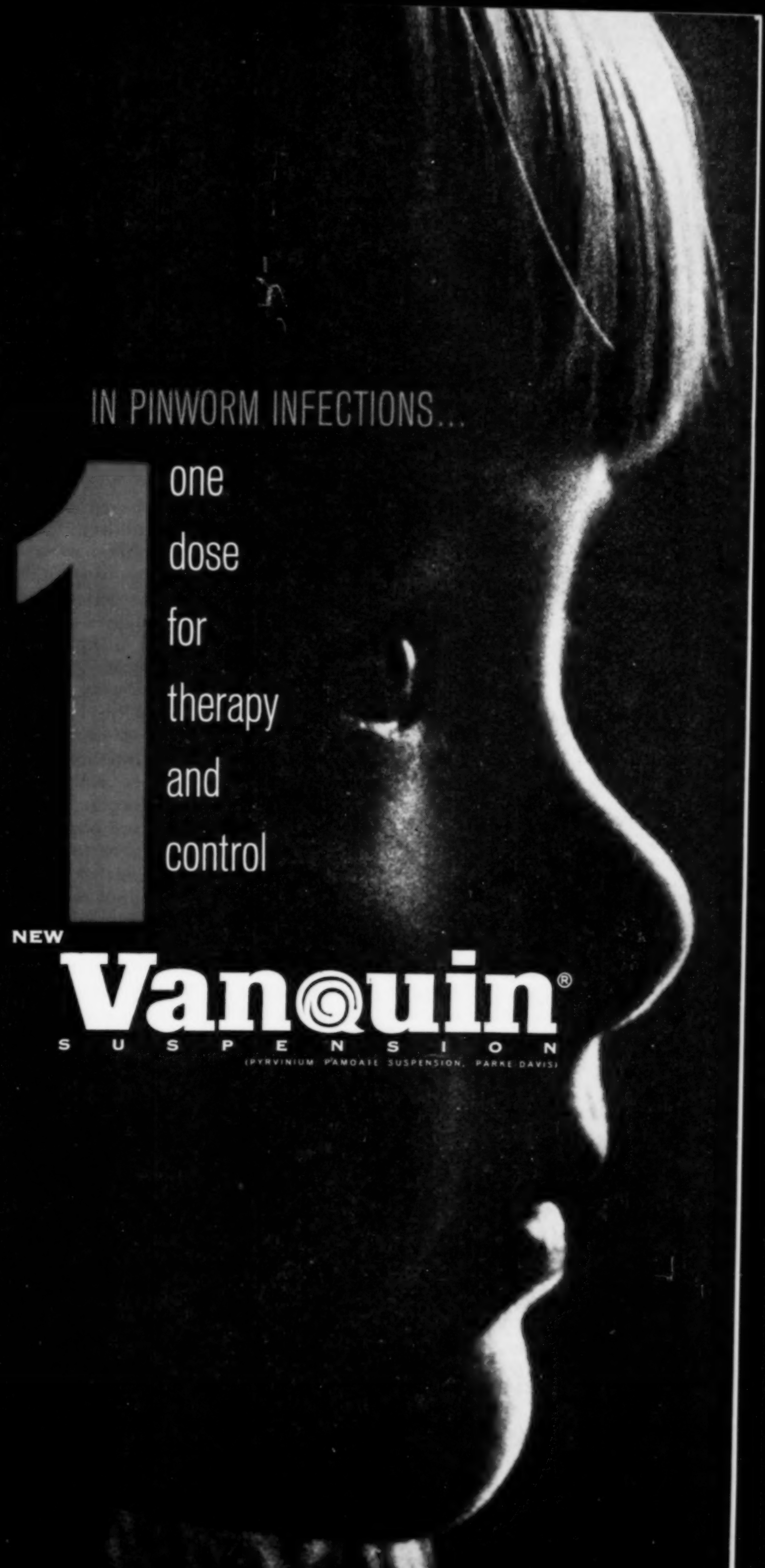

1. The number of people visiting at any one time would be decreased if the hours were increased.
2. The patients in the rest of the hospital may have visitors every day.
3. Visitors would not have to remember what nights they could visit; thus embarrassment of the receptionist, nurses and visitors might be avoided if the visitors arrived on a non-visiting day.
4. There would be no resentment on the part of patient and visitor if some visitors were allowed and others were not.
5. Some visitors were entering by the side door on non-visiting days, so it was thought that better control over visitors could be established.
6. Visiting every day would establish better public relations.

Methodology

Data was gathered by observing patients before, during and after visiting hours and interviewing patients and staff. The latter included staff doctors, residents, graduate nurses of all levels and the group social worker. All were chosen at random.

The patients who were interviewed and observed will be divided into four groups of five each, according to diagnosis: depression, schizophrenia, anxiety and senility. Questions asked the patients were:

1. Who were your visitors — relatives and/or friends?
2. How frequently did they come and how long did they stay?
3. How did you spend your time with your visitors?
4. What were your reactions to your own visitors and to those of other patients?

Findings

Depressed patients:

This group of patients had few visitors because they did not wish to be bothered with people except members of their immediate families. Several patients had only their husbands or wives visit because they felt it was a social disgrace to be in a mental institution; their friends did not know that they were in hospital. The visitors came on an average of three or four times a week and stayed the full length of time allotted or longer. The time was spent mainly in their own rooms, often in complete silence for long intervals.

> One patient went with her husband to some of the dances and sometimes played cards on the ward, because her husband thought it was best for his wife. The husband found it easier to put in the time by becoming involved in some activity. If they were not involved in activities his wife, who had ambivalent feelings toward him, would remain silent or would leave him alone in her room while she talked with other patients. On the other hand, this patient expected her husband to come each evening *because the hospital had visiting hours.*

The depressed patients displayed varied reactions to their visitors. Some were very demanding and very dependent on their marriage partner and their children. Several displayed anxiety and fear when they were expecting visitors and frequently feelings of guilt were deepened. Some patients became more depressed when their company arrived, bringing many home problems with them.

> A 62-year old female patient from a distant city became depressed while her relatives were with her. She stated that she knew they would be going home and she was unable to go with them. She felt that the length of visits should be shortened because she found she became very exhausted and restless at the thought of being left behind. This patient had to readjust to hospital routine each time her family returned home.

Generally speaking, other patients' visitors had very little effect on these patients. One did have a feeling of rejection because she had none. Several, whose relatives lived out of town enjoyed other patients' visitors. The patients stated that the visitors were useful in helping them to occupy their time, in doing errands for them and in keeping them in contact with the outside world.

Schizophrenic patients:

Their reactions to visitors were not unlike those of the depressed patients. They saw mainly their parents. The visits were frequent and usually lasted for the complete visiting time. One group of patients enjoyed having their parents come because this kept them in touch with reality. They were motivated to pay attention to grooming and to participate in games, such as scrabble. These patients became very

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1. Marks, M.M.: Am. J. Digest. Dis. 18:219, 1951

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dependent on their parents.

The other group of schizophrenic patients had ambivalent feelings toward their parents. They would wait for them and would become very depressed if they didn't arrive. If they did come the patient would become very upset and display hostility toward them.

> One patient would cry if her mother didn't arrive and on other occasions would scream at her mother and then walk out leaving her alone in the room. One young girl would sit with her mother in the day room and completely ignore her. Another patient became extremely depressed after she saw her relatives for the first time following sleep treatment. She realized that she seemed strange and different to her young cousins with whom she lived. She also realized that she had to make an effort to be sociable in order to be accepted. This incident helped her a great deal toward making the necessary adjustment to reality.

Visitors of other patients appeared to have very little effect on the schizophrenic patients.

Anxious patients:

In contrast, these patients and their visitors presented a different picture. In general they had numerous visitors, including family and friends, who came regularly and usually stayed the full visiting time. The visitors who lived in Montreal joined in ward activities because they came often and got to know many of the patients.

> One patient who was from out of town, wished to be alone with his wife. He felt that the length of the visiting hours could be extended because of the difficulty his wife had had in coming to the city. Although he did not include his wife in hospital activities he felt that visitors helped to stimulate the evening program and make it a success. He thought that it was good for the patients to associate with visitors. He had many guilt feelings after his wife left because it brought to focus his failure to support her.
>
> A female patient from Ottawa whose sister came on week-ends, became very dependent. She felt that her sister brought her into contact with the world again. She experienced a great deal of anxiety during her sister's visits. She stated that she was afraid she had not improved enough and that her sister would be disappointed. This patient had very few friends come because she had not let them know where she was. The one friend who came had been a patient in a psychiatric hospital. This friend was enjoyed very much because she offered support.
>
> A 64-year old woman with a diagnosis of anxiety hysteria received numerous relatives and friends frequently and for the full length of time allowed. She enjoyed her visitors greatly. In them she had sympathetic listeners to her various somatic complaints. She did introduce them to patients and staff and joined with them in some hospital activities. Sometimes, when they remained for the full visiting period, she found her visitors exhausting.

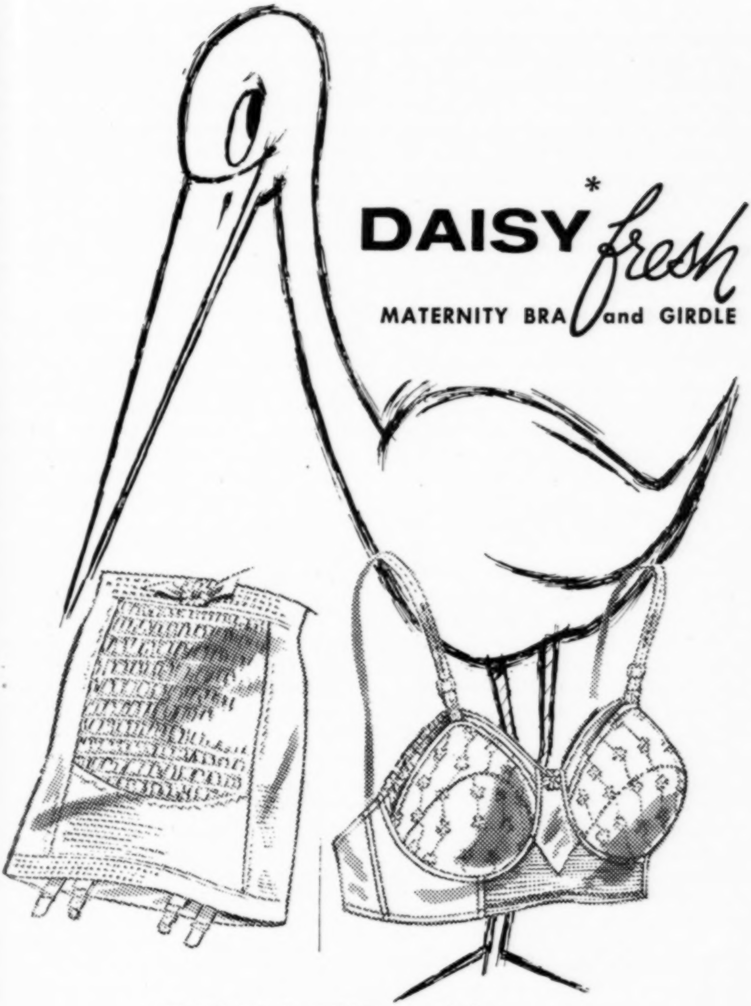
Senile patients:

In this group different observations were made. The visitors did not come as frequently as those of some of the younger patients as they were elderly and not able to come every day. Several of the patients had great memory deficit so did not realize who came, how long they remained or how often they came. They were relaxed and contented while their family was present but became very confused after their departure and made many attempts to leave the hospital. Among the patients who had good memories, old friends as well as relatives came. These patients really enjoyed their visitors. It was a treat and a delight for them to sit down with old friends and reminisce about the olden days. They usually kept their visitors to themselves. They were seldom affected by other patients' visitors.

Conclusions

In comparing these four groups of patients, it would appear that depressed and schizophrenic patients had fewer visitors, mostly members of their families. The anxiety and senile patients received friends as well as members of their families.

The frequency of visits and the length of individual visits with each patient varied with factors such as where the visitors lived and whether they became involved in ward and hospital activities, such as dances and movies. The evening visiting time, 7:00 P.M. - 8:00 P.M. overlaps with the movie time, which is 6:30 P.M. and



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the dance time which usually starts between 7:30 and 8:00 P.M.

The depressed patients became extremely dependent on their relatives. Some became more depressed and had to readjust each time their visitors left. Many times the presence of visitors produced more guilt feelings in the patients. Some depressed patients became more depressed when other patients had visitors and they did not. This caused a feeling of rejection.

In the acute stages, the schizophrenic patients would be better if they received no visitors, particularly their parents. The main objective in treatment is to remove them temporarily from their environment because they are unable to accept it. After treatment and before discharge, it would seem to be valuable for these patients to receive visitors. They would help the patient to establish contact with his former environment while the patient was still getting protection from the hospital; this would be a temporary situation between complete isolation from the outer world and living in the community.

The anxious and the senile patients benefited from visitors. They enjoyed mixing with all the visitors and generally had a social evening with them. On the whole, visitors helped these patients maintain contact with the world even though at times anxiety was produced. The senile patients received fewer visitors than others, but they definitely enjoyed them.

Opinions of the Staff

The doctors were asked the following questions:

1. How frequent and how long should visiting hours be in a psychiatric hospital?
2. What effects do visitors have on the patient?

There were different opinions on the above questions, but one answer all doctors gave was that visiting should be determined on an individual basis.

Some doctors stated that in the acute phases of illness, visitors should not be allowed. Others expressed the opinion that patients should not have visitors for the first week or two. Mental illness develops when the person is unable to handle conflicts between self and outer stimuli. In order to treat these people they are removed from the home environment. An attempt is made to establish a new pattern of life and to learn how to deal with interpersonal relations in a controlled situation. If the patient is able to have his environment brought to him in the form of visitors from the time he is first admitted, the purpose of hospitalization is defeated. There are times when there are exceptions that would prove worthwhile, for example, in the case of a language barrier. One doctor stated that if the patient's environment was brought to him in the form of visitors, he might as well be treated as a day patient or on an outpatient basis.

Several doctors felt that there should be no set rule for visiting. The patients should be able to receive visitors whenever it is convenient for the staff. It was stated by some that it wasn't the frequency of visitors, but the type that counted. If a patient has guilt feelings toward a parent, the presence of this person would only increase the feeling of guilt; if someone felt rejected and unloved he should have visitors so he wouldn't feel this way. He should be permitted to gain support and reassurance from his visitors. Some visitors try to encourage patients into activity before they are emotionally ready; this can deepen depression. Some doctors stated that only relatives and close friends should be allowed, as acquaintances may come only to satisfy curiosity and to spread gossip. An individual's acceptance in the community could be destroyed if acquaintances saw him in acute stages of illness where he had lost control.

One doctor stated that if it were advisable for a patient to maintain contact with his former environment, visitors should be allowed only once a week. Three interesting comments were made regarding visiting on a once-a-week basis. The patient would anticipate a visit with pleasure. If he did not wish to receive visitors, there is only one day a week when he has to worry about it and have feelings of guilt because he rejected or wished to reject them. Also, a better evaluation of the patient's progress toward handling social situations can be made.

An overall value was that visitors helped the patients to maintain con-

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tact with reality, to better handle social situations and to become rehabilitated.

A side-effect of visiting hours in a psychiatric hospital is public education. They see the various types of patients and realize that they do not appear to differ greatly from people met in everyday life. They begin to understand that many patients do return to a normal way of life. The visitors are able to go to the patients' rooms. They are reassured that the patients are comfortable in the hospital.

In interviewing graduate nurses, they gave the following responses:

It was generally conceded that the patients should have visitors though visiting hours should be regulated to meet the individual patient's needs. About 30 per cent of the nurses thought there should be visiting hours every day; the rest believed that every other day would be sufficient. The latter group felt it too exhausting for the patients thus keeping them from making full use of the planned hospital activities. Another opinion was that the patient could become too dependent on visitors thus preventing him from learning how to be independent.

One nurse stated that the patients should not have visitors for a week following admission. The patients could then adjust to the hospital and establish a routine before having to adjust to visitors. On the other hand, another nurse thought that open visiting hours should be established so that following favorable advantages might result:

> Visitors would not stay as long when they knew they could come at any time; patients would not wait for visitors at established times and then be disappointed if no one arrived; patients who received no visitors would not become as disturbed as they would if the majority of the patients had visitors at one time.

Most nurses thought that open visiting hours would not be satisfactory. Some disadvantages stated were:

> Patients needed an established routine and it would be disturbing for them to receive visitors throughout the day; they would continually wait for visitors and perhaps refuse to take part in organized hospital activities.

It was generally agreed that visitors keep the patient in contact with reality. At times visitors may be a help to the hospital staff. For example, they may be able to confirm information that the patient has given about delusional patterns and personal traits. Also, if a patient sees that his relatives have confidence in the hospital, he may follow their example and form a more confident relationship with the staff. On occasion, a visitor may help to calm the patient, particularly if there is a language barrier. Visitors help the patient to occupy some time and give them a reason for consciousness of their personal appearance.

The nurses seemed to agree with the doctors that visitors helped the patient to maintain an interest in life. Visitors give support to the patient and in many instances help him to realize that he is not being rejected. The nurses noted that visitors help make the patient aware that he has to behave in a manner which is acceptable. This helps in his ultimate rehabilitation.

Conversely, there are disadvantages in patients having any visitors. Sometimes, a relative will so identify himself with the patient, that he gains incorrect ideas regarding the hospital and then interferes with treatment. Patients tend to develop a feeling of dependence on visitors and become depressed if they do not arrive when there are visiting hours.

Visitors exhaust some patients. On occasion a visitor so sympathizes with an acutely psychotic patient that he is persuaded to take the patient home. Anxious relatives may pass on their anxiety. Some patients, such as schizophrenics, have strong negative feelings towards their parents so that their presence will interfere with treatment. Visitors should be instructed regarding the best approach to the patient and should be told in what condition they will find him.

Opinions differed about whether evening visitors helped promote the evening program. In theory, it was thought to be a good idea to have the relatives and patients join in the activities together. In practice, it was noted that patients preferred to remain on the ward with their visitors. Frequently they used the excuse that they were waiting for company so they wouldn't have to participate.

The group social worker stated that

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visitors should stimulate the evening program. For instance, it would be natural for a man to attend the dance with his wife. The worker believed this would be an excellent form of public education because the general public could see that the psychiatric patients participate in normal activities.

As for visitors interfering with occupational therapy, the therapist stated that if the patients were interested in the therapy, they could receive their visitors in that department.

It is apparent that the subject of visitors in a psychiatric hospital is very complex. Questions must be answered on an individual basis. There is no overall agreement as to how soon the patients should be allowed to receive visitors after admission nor how frequently visitors should be allowed to come. It is agreed that visitors do help the patient to maintain contact with reality and community life. It is recommended that visitors be instructed about how to approach the patient, so as not to interfere with the general planned program.

Hebephrenic Schizophrenia

SISTER MARIE ELISE, F.D.J.

Schizophrenia is most common during the transition period between adolescence and early adulthood. It may occur later in life as this case study shows.

Social and Personal History

MISS MARY ROY, aged 49, was one of three girls in a family of five. Her father was a farmer and until 10 years ago she lived at home. Her parents were third cousins, her mother having died some years previously following paralysis. There is no known mental illness in the family history.

According to Miss Roy, her childhood was uneventful but she has always felt that she was the least loved of the children. She completed Grade VI and had no difficulty with school work.

Miss Roy is quiet, almost docile. She has no friends, preferring to stay at home, becoming increasingly reserved and timid. She attends church with her family but is not particularly religious. Most of her time is spent alone—in a rocking chair listening to the radio. She has no hobbies and is not interested in any games. She has never shown any interest in the opposite sex.

Her menstrual periods began when she was 14 and have always been preceded by lower back pain and irritability.

History of Present Illness

Miss Roy's illness began when she was 35 years of age. Eight or ten days before the onset of her menstrual period she displayed personality changes, and became disinterested in her usual activities. Ten years ago she was hospitalized for hebephrenic-catatonic schizophrenia. She was treated with Largactil 50 mg. t.i.d. and Phenergan 50 mg. at bedtime.

Two months later on discharge, she was much improved. She stayed in the city to work as a domestic. She was a good worker, though slow, and remained with the same employer until six months ago when she returned to her brother's farm. During the past six months her symptoms have recurred. Her condition became increasingly worse until it was impossible to care for her at home. A sister gave the following history:

> Each month prior to her menstrual period her behavior changes. She has high blood pressure and will not follow her diet. If anyone suggests or insinuates that she ought to, she becomes angry.

Sister Marie Elise is a student nurse at the Hôtel Dieu Hospital in Quebec City.

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She cannot bear to be contradicted. She will never do anything that she is asked, in fact, usually does the opposite.

During these periods she rarely eats or sleeps. She mumbles all night — talking or singing to herself. She may spend the night walking either in the house or out of doors. She does not care for herself — neither washes nor keeps her hair tidy.

Without provocation she tears my clothes to pieces, hits me and pulls my hair. Her emotions are confused. She is reckless; she rarely cries though she frequently laughs to herself. She is often incoherent during these episodes.

When her menstrual period begins she becomes quiet — in several days she seems almost normal. This pattern is repeated each month.

Physical History on Admission

Miss Roy has frequent headaches and fainted once. She has had no other illnesses.

On admission, the patient responded poorly to questioning and mumbled to herself. Her speech was inarticulate and incoherent; her ideas fantastic and changeable; her responses were inaccurate, slow, spoken without conviction. She seemed to be indifferent; thinking of other things.

Mental Capacity

She was moderately well oriented as to time and place. Her memory for past events was good, but for recent events poor. She tried to enclose herself in a world of her own; she was not interested in those around her; she was completely autistic. Her judgment was poor; she was not self-critical. Some time later she acknowledged that she required hospitalization.

Observation of the Patient

Miss Roy's deportment on admission was bizarre. She held herself immobile, numb, expressing no emotion, no perception; she seemed a stranger to the external world. She appeared neglected and wore a shabby dress. Her facial expression in particular was peculiar; her eyes were half closed, she was pouting and conveyed an expression of stupidity.

At first she was silent, then slowly and with difficulty she answered questions. She felt that the world was against her, her brother especially. She was slightly incoherent.

Being in the hospital did not seem to affect her. Her complete indifference was marked. She was quite inactive, showing interest in nothing. She slept well with medication, her appetite was good, her moods variable. When she was encouraged and helped to mix with the other patients she did not respond.

Occasionally she would notice those around her and then return to solitude. She answered when spoken to, but never asked questions or started a conversation.

To outward appearances — she was a quiet patient, who sometimes lay still for several hours with a blank expression on her face. She did not seem to be thinking — she showed no emotion.

Treatment

Medications rather than electric shock therapy were the doctor's choice. From the beginning of her hospitalization she received the same drugs she had been taking at home. There was steady improvement in her mental state. When she was not given her drugs for a trial period, the symptoms recurred within eight days. She took her medications without hesitation.

Her blood pressure decreased as a result of the tranquillizers. It was maintained at 130/80. She ate well and never complained of physical pain. She always said that she felt well.

Progress

The bizarre ideas gradually disappeared, although marked emotional indifference remained. Alternately she appeared agitated and stupid. The self-criticism became more real. In general her deportment was better.

Prognosis

Most patients with this condition have a recurrence of symptoms. On the other hand, if Miss Roy takes her medications faithfully she may have continued remission as she had for ten years. She is capable of gainful employment again. She accepts the situation and is not disturbed about the future.

It is important for this patient to follow the directions of her doctor carefully and to visit him regularly.

The Greatest of These

I have been climbing the professional totem pole, one academic degree after another. But is this nursing?

While I am in committee meetings discussing whose duty it is to chart temperatures, my patients are doing without good old-fashioned nursing care.

The child with a skull fracture doesn't care one whit whether I took a baccalaureate degree in philosophy, or even a master's. Her immediate need is to be comforted, to feel a sympathetic presence. She needs medication, too; and I am able to administer it in the prescribed fashion because I am a *nurse*.

Nursing was once a pyramid with a broad, firm foundation of general staff nurses who practised their profession faithfully because they were dedicated to service. Only a few at the top handled management detail.

Gradually we have inverted the nursing pyramid. The now broad top is peopled by a growing multitude of administrators, coordinators, managers, expediters, directors, and consultants — all of them far, far removed from the patient. At the bottom is an ever-slimming base of staff nurses. Isn't it about time we took a look at what is happening?

Graduating students are seldom encouraged any more to enter staff nursing with the idea of making it a specialty. Instead, staff nursing is looked on as a stepping stone to the "higher" positions.

Why not give the dedicated staff nurse opportunities for advancement in status and salary in her chosen field — rather than make her feel like a backslider because she does not aspire to be a supervisor?

More and more weight is now put on academic learning. Less and less is put on practical application of that learning. With the 40-hour week, the student's bedside practice was reduced; but at the same time her classroom hours were increased.

I would like to see young graduates required to give at least one or two years to staff nursing before being permitted to apply for administrative jobs or even to enter advanced courses in nursing education. (A senior student at a large hospital in the Midwestern United States recently received her appointment as an assistant director of a nursing service three weeks before she had received her diploma!)

I would further like to see every member

(See page 267)

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Nursing Profiles

Kathleen Elizabeth Arpin has been appointed assistant director nursing education of the School of Nursing, Toronto General Hospital. She replaces Helen (McLaren) Rafuse who resigned from the position shortly prior to her marriage.

Kathleen Arpin

Miss Arpin is a graduate of St. Joseph's Hospital, London and holds her Bachelor of Science degree in nursing education from the University of Western Ontario. Following graduation she spent a number of years on the staff of the University Hospital, Ann Arbor, Michigan. During 1954-58 she was assistant director of the school of nursing, Metropolitan General Hospital, Windsor. Immediately preceding her present appointment she was employed as a nursing education supervisor at T.G.H.

While she was working in Windsor, Miss Arpin took an extremely active interest in the local chapter and district activities as a committee member and member of the district executive. She enjoys her record collection and she also has a yen for travel.

Patricia Mary Neville is now nurse consultant to the Alberta Civil Defence Staff. Born and educated in Ottawa, she was employed by the City of Ottawa Recreational Department and later by the British Government Technical Mission, United Kingdom and Canada, during the first years of World War II. Following this, she entered training at St. Joseph's General Hospital, Peterborough. Since her graduation, she has done operating room work at the Royal Ottawa Sanitorium, public health nursing in the rural areas of Ontario and emergency nursing in the Vanderbilt Clinic, Presbyterian Hospital, New York City. Most recently she has been on the staff of the Misericordia Hospital, Edmonton as charge nurse in the emergency department. Miss Neville will assist in the further development of civil defence services in Alberta.

Brian Watkin has joined the staff of *Nursing Times,* London, England, as an assistant editor. A graduate of Ipswich Borough General Hospital, he is a nurse turned journalist. Formerly connected with a firm of medical publishers as a sub-editor, he has also had experience as the assistant editor of a political weekly and as a freelance writer on nursing and health service topics. He has been a contributor to *Nursing Times* since his student days and has been a first prizewinner in essay competitions on two different occasions.

Sister Ste Solange Fouquet

Sister Ste Solange Fouquet, a member of the order of the Sisters of St. Francis of Assisi, has been made a Fellow in the American College of Hospital Administrators. The honor was conferred upon her at an impressive ceremony held in the Metropolitan Opera House, New York.

Sister is a graduate of Hôpital St. François d'Assise, Quebec City and of Laval

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By **LUELLA J. MORISON**, R.N., M.A., Nursing Education Consultant, Ohio Department of Mental Hygiene and Correction; formerly Director of Nursing Education and Student Guidance, Mt. Carmel Hospital School of Nursing, Columbus, Ohio. Ready in March, 1960. 3rd edition, approx. 384 pages, 8¼" x 10½". About $4.75.

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By **ALICE LORRAINE SMITH**, A.B., M.D., Pathologist, J. K. and Susie L. Wadley Research Institute and Blood Bank, Dallas, Tex. Just published. 7th edition. 725 pages, 6¾" x 9½", 316 illustrations. Price $7.50.

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Designed for use in courses in "General Pathology" or "Introduction to Medical Science" in schools of nursing offering a diploma program, this thoroughly revised and modernized book places emphasis on the mechanisms of disease and organisms. The author, an outstanding physician and pathologist, provides an up-to-date discussion of recent advances in the field including new antibiotics and newly available methods for inhibiting or destroying microbes. A new chapter deals with injury produced by nonliving agents and includes a discussion of nuclear medicine and radiation pathology.

New 2nd Edition

By **AUSTIN FAGOTHEY, S.J.**, Professor of Philosophy, University of Santa Clara, Santa Clara, California. New. 1959. 2nd edition. 627 pages, 5½" x 8½". Price, $6.00.

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Written especially for a full-year, Catholic orientated college course in ethics, RIGHT AND REASON gives students a clear, practical understanding of the current ethical problems of everyday life. This book provides a modern presentation of the Aristotelian-Thomistic interpretation of ethics from the "problem" method rather than the "thesis" method. Each chapter covers historical background on a problem, alternative philosophies and arguments and a concise summary of the investigation. You will find this new 2nd edition extensively revised — the topics of happiness and the end of man have been rewritten to clarify the philosophical approach and distinguish it from the theoretical; reflections on logical positivism, relativism and existentialism have been introduced; and the terminology simplified.

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University. She later became the administrator of her home hospital for a period of 12 years. She is now the superior and director of nursing at Hôpital Ste Jeanne d'Arc, Montreal. Our congratulations and good wishes are extended to her.

In Memoriam

Ella Marie Ronnow Andersen who graduated from Den danske Diakonissestiftelse, Copenhagen, Denmark in 1948 died during 1959.

* * *

Madeline Orr Armour, a graduate of the Royal Infirmary, Glasgow, Scotland in 1925 died during 1959. She had engaged in occupational health nursing and for some years she was on the staff of the Forest Ranger School, Dorset, Ontario.

* * *

Lottie (Yaneosiski) Bush who graduated from St. Paul's Hospital, Vancouver in 1913 died during 1959.

* * *

Gladys B. Carter, a graduate of King's College Hospital, Surrey, England died on December 7, 1959. Prior to obtaining her nursing preparation, Miss Carter had been a lecturer in economics and practising midwife. Following the war she came to the University of Toronto School of Nursing as a lecturer. Later as the first holder of the Boots' Research Fellowship, University of Edinburgh, she helped develop plans for the new Nursing Studies Unit. She was also a nurse consultant to the Second Expert Committee on Nursing, World Health Organization.

* * *

Josie (Gibson) Conway, a graduate of St. Michael's Hospital, Toronto in 1917, died on September 11, 1959. Following her graduation, she worked with the Department of Health, Toronto for a time.

* * *

Gladys (Pepino) Dawson, who graduated from Oshawa General Hospital in 1917 died in the spring of 1959. During her professional career she had engaged in private nursing.

* * *

Zella Viola Douglas, a graduate of Toronto General Hospital in 1925 died on December 5, 1959. She had engaged in private nursing during her professional life.

* * *

Eugenie Le Noblet Duplessis, a retired Quebec nurse, died on December 10, 1959. She was 86 years of age. At the start of World War I she joined the Canadian Army Medical Corps as a member of the Winnipeg Ambulance Unit. Later she enlisted in the active force and went to France where she served as an assistant matron. In recognition of her services, she was awarded the General Service Medal and the Victory Medal. Following her return to Canada, she joined the Department of Indian Affairs and was posted to a reservation at Nanaimo, B.C. She remained there until her retirement in 1942.

* * *

Frances White (Phelps) Foote who graduated from the Toronto Western Hospital in 1939, died on October 29, 1959.

* * *

Mae Leafa (Linn) Gould, a graduate of the Nicholl School of Nursing, Peterborough Civic Hospital in 1938, died on May 17, 1959. She had engaged in private nursing.

* * *

Marion Janet Herriman who graduated from Kingston General Hospital in 1945, died November 24, 1959. She was employed in institutional nursing.

* * *

Lillian I. Lawrence, a graduate of St. Luke's Hospital, New York died on December 28, 1959. Many years ago she was on the staff of the Toronto Department of Health.

* * *

Luella McKnight, a graduate of Oshawa General Hospital in 1924, died on September 27, 1959 after a long illness. She had devoted her professional life to private nursing.

* * *

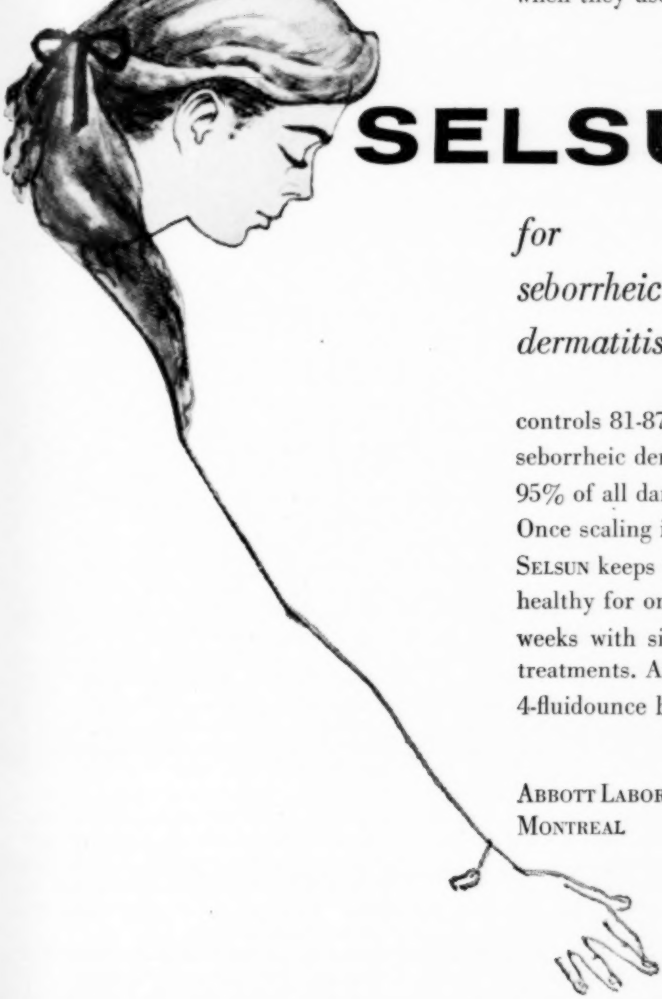
Rita (Marwood) Pauline who graduated from St. Joseph's Hospital, Victoria in 1919, died recently in Vancouver.

* * *

Margaret (McKenzie) Pitts who graduated from St. Joseph's Hospital, Victoria in 1920, died recently.

* * *

L. Clara Preston, a graduate of Royal



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Victoria Hospital, Montreal in 1922 died suddenly on December 4, 1959. She was a United Church missionary nurse in China for almost 21 years and, prior to her retirement, was matron of the United Church Hospital, Burns Lake, B.C.

* * *

Mary Margaret (Curtis) Ruddy, a graduate of Oshawa General Hospital in 1941 died on September 20, 1959. Following graduation she was head nurse in the admitting and emergency department of her hospital for several years. Later she became assistant superintendent and eventually associate director of nursing service.

* * *

Sister Mary Romanus (Pearl Hushin) who graduated from St. Joseph's Hospital, Toronto in 1933 died during July, 1959. She was engaged in institutional nursing.

Book Reviews

Psychology as Applied to Nursing by Andrew McGhie, M.A. 247 pages. The Macmillan Company of Canada Limited, 70 Bond Street, Toronto. 1959. Price $3.00.

Reviewed by Mrs. C. Yannikosta, Clinical Instructor, University Hospital, Saskatoon.

The author states in the preface that his aim is to introduce psychology to the student nurse in a manner that will make its study as painless as possible. The need for and importance of this subject in preparing the nurse to give more effective care to her patients and to gain a better understanding of her own personality is well recognized by modern nurse educators.

This book is presented primarily as a basic introduction to psychology for the student nurse. Certain specific areas must be supplemented by reference reading in order to reach the desired comprehension of the subject under discussion. The author has succeeded in presenting his material in a very effective and stimulating manner. He "talks" to the nurse, using many examples and anecdotes to illustrate and to emphasize his material. Simple, non-technical terminology is used whenever possible and definitions are moderately numerous.

The content seems to be structured in the most logical, practical way possible. The author begins with a study of human behavior progressing from the infant to old age. This is followed by a discussion of the forces that motivate individual behavior, the interaction of environment and a study of the individual as a social being.

At the end of each chapter there is a short summary entitled "Concluding Remarks." This should be of great value in helping the student to assimilate the highlights of each section. Suggested questions at the end of the chapters provide excellent teaching material as out-of-class assignments or for discussion groups.

This appears to be a satisfactory text for student nurses and a helpful guide to the instructor who teaches an introductory course in psychology.

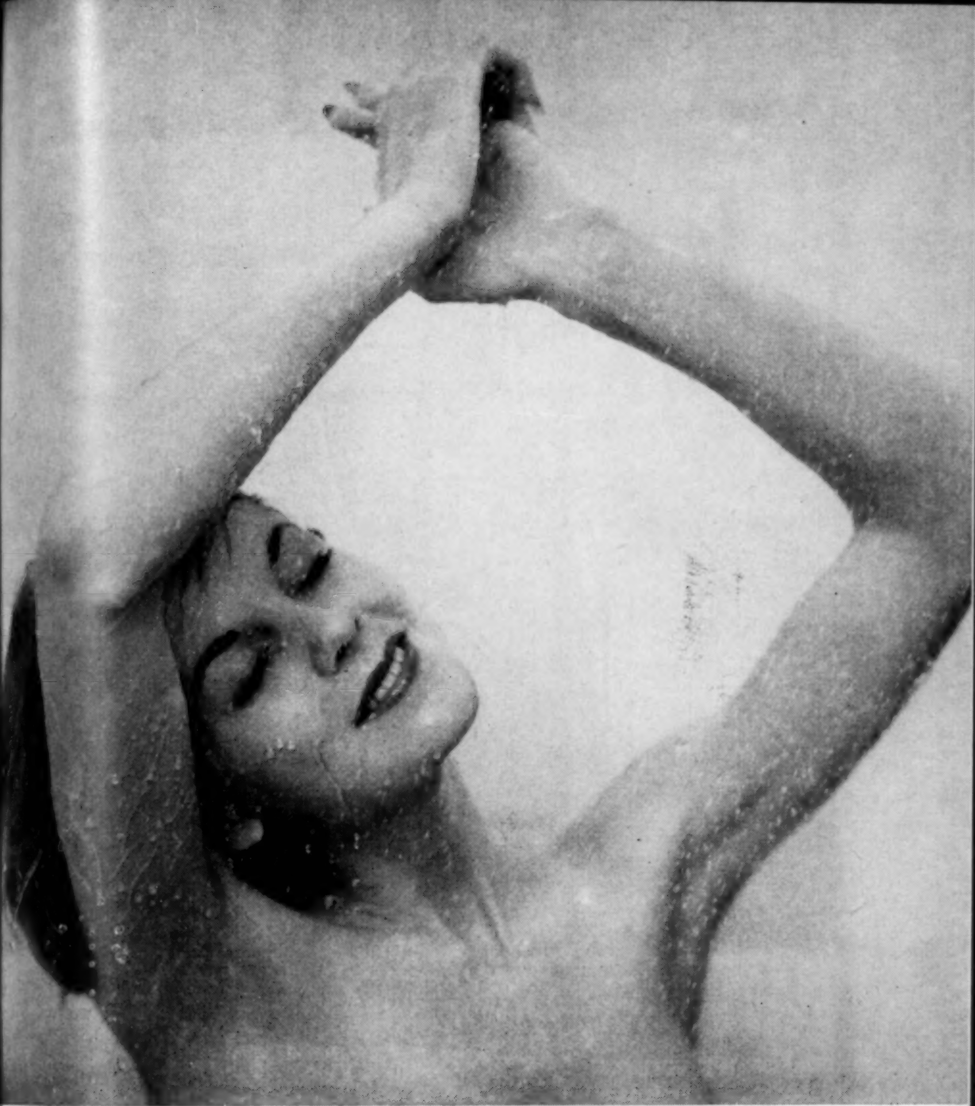
Medical and Surgical Nursing Part II by Amy Frances Brown, R.N., B.Ed., M.S. in N., Ph.D. 850 pages. W. B. Saunders Company, West Washington Square, Philadelphia. 1959. Price $8.00.

Reviewed by Miss P. McBride, Winnipeg General Hospital, Winnipeg, Man.

The author's objective was to provide the nursing student with a compact text dealing with advanced medical and surgical nursing or the so-called "specialties." These have all been adequately discussed.

Approximately one-third of the content deals with infectious diseases. There is much detail in this area that will not be of too much value to the student nurse in Canada. The remainder of the material, however, is excellent. The discussion of medical and surgical emergencies is particularly useful and timely. It will provide both the student nurse and the instructor with concrete information.

Charts and graphs have been used to good advantage. The statistics presented in this manner come alive to the reader and are more meaningful to her. Photographs and illustrations have also been included effectively to emphasize specific points and descriptions. The area on dermatology is particularly well illustrated. Case histories help to make the content more vivid.



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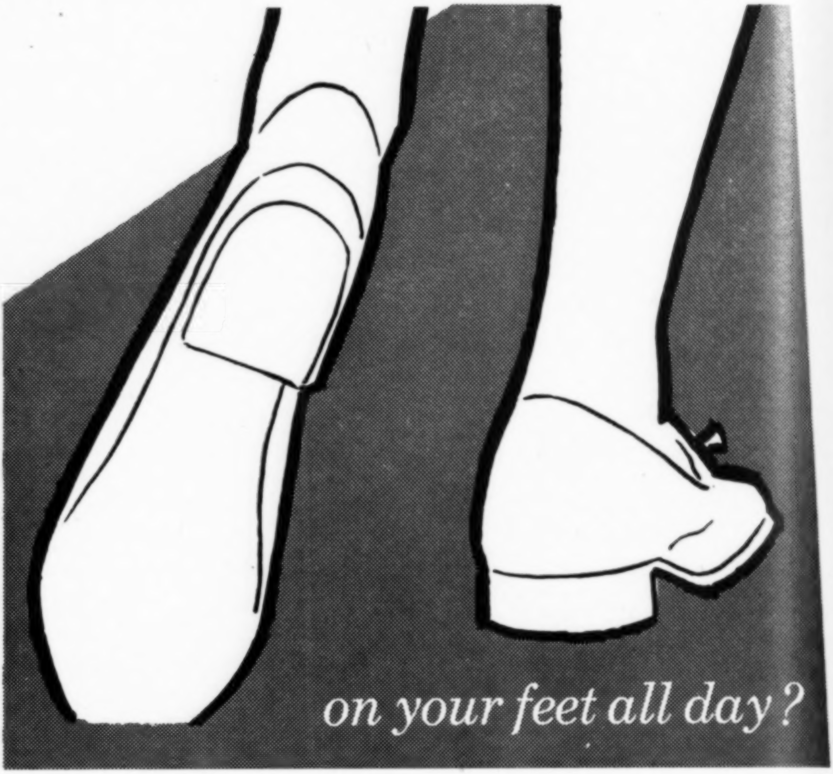
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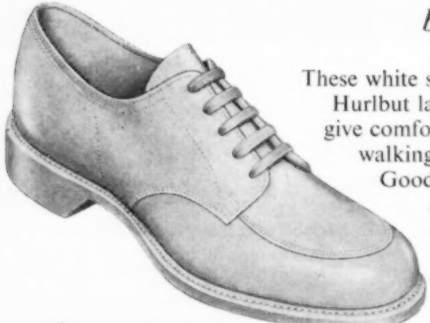

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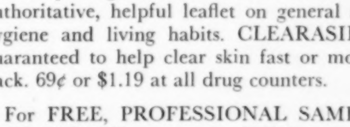

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Orthopaedic Nursing by Mary Powell, S.R.N., M.C.S.P. 464 pages. The Macmillan Company of Canada Limited, 70 Bond Street, Toronto. 3rd ed. 1959. Price $4.70.

Reviewed by Miss Ruth Kelsall, Winnipeg General Hospital, Winnipeg, Man.

The author states that "this book is written primarily for nurses and physiotherapists working in orthopedic hospitals . . . It is hoped that it will prove useful to those engaged in orthopedics in the wards and departments of general hospitals, and to those working in sanatoria . . ."

The content is introduced with a discussion of the basic principles involved in orthopedic treatment. This includes positioning, traction, physiotherapy, plaster of Paris techniques, splints and appliances. The necessary nursing care involved in each of these areas is outlined. The introductory section is followed by detailed descriptions of the various orthopedic conditions. The author gives particularly good attention to the specific nursing care required.

There is a large section devoted to the care of patients with tuberculosis of bones and joints. Even though this condition is now seen with less frequency in some countries the author feels that the same basic principles for nursing these patients can be of benefit to the nurse as she works with those who have other orthopedic conditions.

There are many good illustrations and diagrams. However, as this book was written in England, some of the equipment shown appears to be more specific to England than to Canada. There is no discussion of the Stryker frame and some of the developments in orthopedics. The book is most valuable in giving the nurse a sound understanding of the basic principles in orthopedic nursing, but it does not inform her of the more recent developments in this field in Canada.

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* * *

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Canada's history is a history of the immigration of the multitude of ethnic groups which arrived to embrace the opportunities it offered. The love of country borne by these immigrants and their descendants and the individual dignity bestowed upon them has evolved to give to the modern world a nation known as "Canada" and its inhabitants who proudly bear the distinctive title of "Canadian."

In acknowledging the 200th year of Jewish settlement in Canada, much will be noted of the achievements made by individual members of the Jewish community and of the contribution the community, in general, made towards Canada's flowering as a nation in its own right. However, the theme overshadowing all was the constant awareness that there existed a land that had made all of this possible. That in this land ideals and dreams were not only brought to fruition but became an integral part of its heritage. The Bicentenary Year was one of gratitude and thanks to their country on the part of its citizens of the Jewish faith.

— *JIAS News,* October, 1959

* * *

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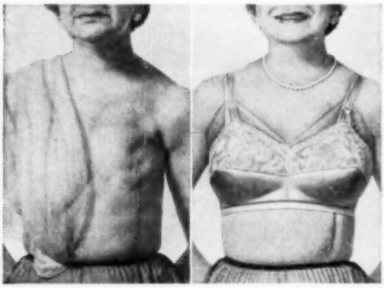

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A Poem for Probationers

The skeleton hangs in the classroom,
His bones are plain to view
Do you ever think he once had a heart,
And warm-blooded flesh, like you?
Do you ever think as he hangs there,
So dumb to student fears,
That he once studied anatomy,
And probably shed tears?
So while he swings so merrily,
Give thought to the former man
Did he ever dream he would rattle?
Study his bones if you can!
One of those days your bones may swing,
For some inquisitive clan!

JANE JOHNSON

* * *

Look beneath the surface; let not the several quality of a thing nor its worth escape thee. — LAERTIUS

* * *

Let there be spaces in your togetherness.
— KAHLIL GIBRAN

* * *

Have you had a kindness shown? Pass it on. — HENRY BURTON

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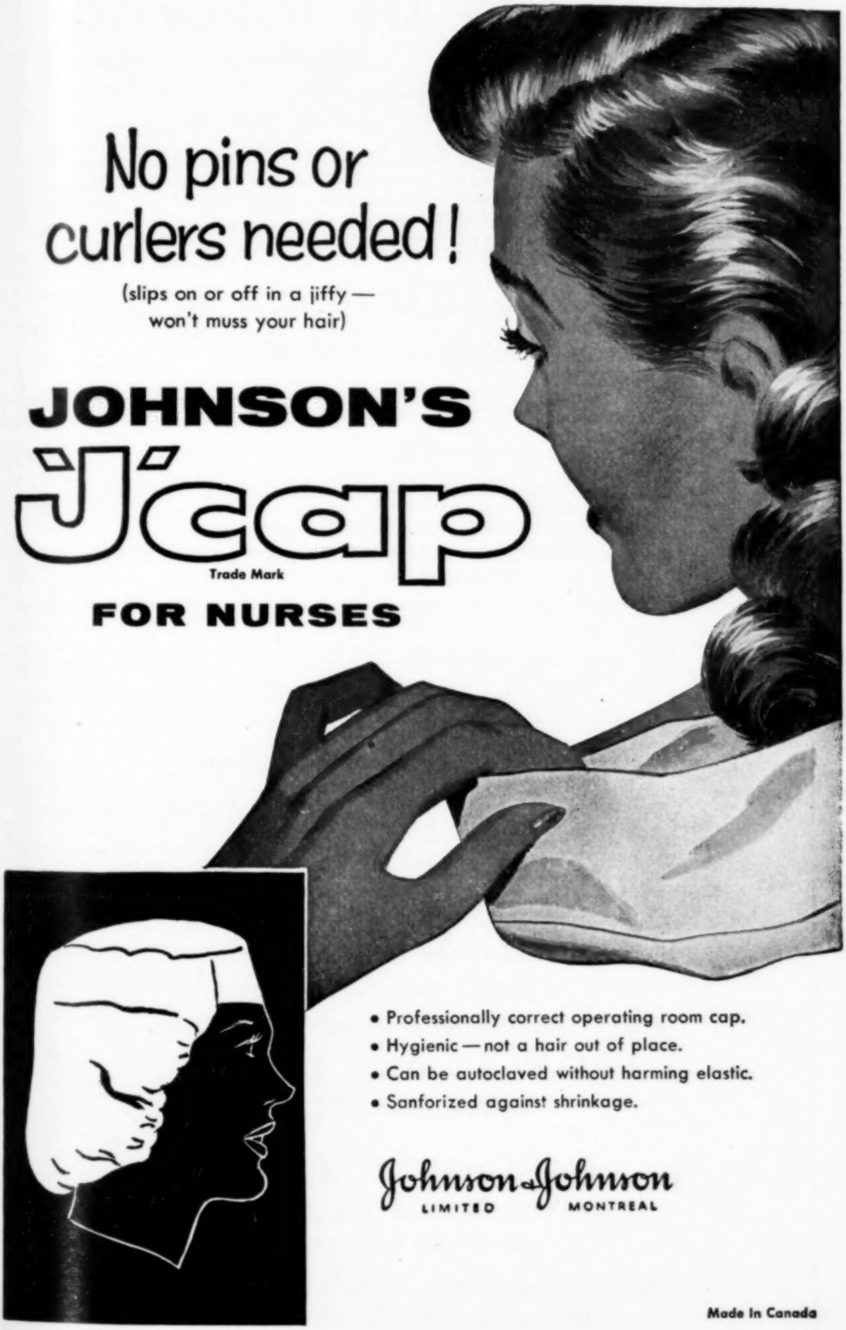

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Nightingale School of Nursing

Arthur J. Swanson, F.A.C.H.A., has been appointed chairman of the Board of Trustees of the new Nightingale School of Nursing. The school, which is being developed under the auspices of the Ontario Hospital Services Commission, will be located in central Toronto. It will be opened in September, 1960.

The purpose of establishing the school is to improve the quality of nurse education while helping to alleviate the shortage of nurses by giving a two-year course. It will be modeled on the program of Toronto Western Hospital School of Nursing, but will omit the one year of internship.

ARTHUR J. SWANSON

The advisory committee is made up of the following members: Sidney Liswood, administrator, and Ella Howard, director of nursing, New Mount Sinai Hospital; Nettie D. Fidler, director of the University of Toronto School of Nursing; Dorothy Riddell, senior inspector, nursing branch, Ontario Department of Health; Gladys J. Sharpe, senior consultant in nursing, Ontario Hospital Services Commission, and M. Blanche Duncanson, director of the new school.

To the motorist

1. Winterize your driving habits as well as your car. Snow tires and low speed, for instance, always help during winter months. So does gentle brake-pumping.
2. Leave your car behind if you plan to indulge in anything stronger than coffee.
3. Stop driving the minute you feel overtired. The overtired driver is likely to kill or be killed.
4. Make sure your window wipers and defroster always operate efficiently.
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International Trends in the Birth Rate

In many countries throughout the world the birth rate has fallen almost continuously from the relatively high levels reached in the immediate postwar years.

Finland experienced a sharper decrease in birth rate than any other country in Europe; the rate there fell one third — from 28.0 per 1,000 population in 1947 to 18.5 in 1958. Over the same period, Sweden, Denmark, the Netherlands and Czechoslovakia recorded reductions of about one quarter.

Very likely as a consequence of improved economic conditions, the birth rate in England and Wales has turned upward in recent years. After falling from 20.5 per 1,000 in 1947 to 15.0 in 1955 the rate rose to 16.4 in 1958. Last year's rate was higher than the 15.1 per 1,000 recorded in 1938, the last prewar year. Scotland shows a trend similar to that for England and Wales. The birth rate in recent years has also tended upward in West Germany, rising from a postwar low of 15.8 per 1,000 in 1953 to 17.0 in 1958. At the same time, the rate in East Germany decreased from 16.4 to 15.6 per 1,000.

Japan is probably the only country in the world to have reduced its birth rate by about one half between 1947 and 1958; in fact, the annals of vital statistics record few instances in which so marked a decrease occurred in so short a period. The birth rate in Japan dropped without interruption from 34.3 per 1,000 in 1947 to 17.2 in 1957, rising only fractionally to 18.0 in 1958.

Contrary to the experience for many other countries, Canada, the United States, Australia, and New Zealand have experienced a protracted baby boom. In these countries the birth rate in the past decade has been approximately one third greater than that recorded just prior to World War II. In all four countries, the annual number of births in recent years have broken all previous records. There are no indications that the baby boom in the four countries will end shortly.

In many large and populous areas of the world birth statistics are either lacking or so deficient that they are of very limited value. India, for example, reported a birth rate below 25 per 1,000 in 1957, but this is an understatement of the actual situation, resulting from the marked underregistration of births. No reliable figures at all are available for the mainland of China, which is believed to have a population exceeding 650 million.

It is unfortunately not possible to trace the postwar trend of the birth rate in the Soviet Union because of the lack of adequate data. Birth rate figures released by that country for the period 1950-57 show a slight downward trend; in 1950-51 the rate was 26.7 per 1,000 and in 1956-57 it was 25.2.

— *Statistical Bulletin*, Metropolitan
Life Insurance Company

* * *

(Continued from page 251)

of every administrative nursing staff (both in nursing service and in nursing education) required to spend at least one day a year in actual patient care, either as a member of a nursing unit team, or as a private nurse. What new life this would bring to nursing! We would begin to see less emphasis on curriculum and more on character building, less concern over the nursing-hours-per-patient formula and more concern over the human equation.

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MARGARET HELEN ANDERSON, R.N.
Reprinted from *International Nursing Review.*

* * *

In the Massachusetts General Hospital, Boston, a new system of rehabilitation has been started using the nonprofessional services of the hospital — the kitchen, barber's shop, carpentry shop, accountancy department, and so on. The occupational therapist is in close consultation with the foremen of the various departments who supervise and assess the work of the patients who are being rehabilitated in their department. The object of the scheme is to enable the patient gradually to regain his interest in work and to tolerate a full eight-hour working day.

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* * *

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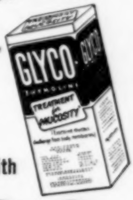

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General Duty Nurses for 110-bed hospital in B.C.'s Northwest. Salary $299 per mo., if experienced; $285 - $342 in 4-yr. Modern residence facilities available. Supervisory positions also available, $330 - $400 per mo. For complete information apply to: The Director of Nursing, General Hospital, Prince Rupert, British Columbia.

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General Duty & Operating Room Nurses for 434-bed hospital with training school; 40-hr. wk., statutory holidays. Salary $280-$336. Credit for past experience & postgraduate preparation; annual increments; cumulative sick leave; 28-days annual vacation. B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Graduate Nurses for 70-bed acute General Hospital on Pacific Coast. Starting salary $275 with regular increases. Board & room $25 per mo., 5-day wk., 28 days vacation plus 10 statutory holidays. Apply: Matron, St. George's Hospital, Alert Bay, British Columbia.

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Registered Nurses for 15-bed U.C. Mission Hospital, 90-mi. from Winnipeg, daily bus service. Salary $295-$335, **Licensed Practical Nurses** $200-$240. Residence accommodation $45 full maintenance. Apply: Superintendent, E. M. C. Memorial Hospital, Eriksdale, Manitoba.

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(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.
(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.
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Registered Nurses 2 (Science Instructor & Nursing Arts Instructor) for school of nursing—60 students. Good working conditions. Inservice education & recreational programs. Write to: Directrice de l'école d'infirmières, Hôtel-Dieu du Christ-Roi, Alma, Lac-St-Jean, Québec.

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Head Nurse — Operating Room in a modern 80-bed hospital. Basic salary $310 with recognition for P.G. courses, university training & for previous experience. 40-hr. work wk., good personnel policies, residence available. Apply: Director of Nurses, Weyburn Union Hospital, Weyburn, Saskatchewan.

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Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Registered Nurses Surgery & General Duty for newly expanded 200-bed hospital located in Southern California. Starting salary $315 per mo. with $10 differential for obstetrics, surgery & night duty, 40-hr. wk. Progressive community near Disneyland. Contact: Director of Nurses, Miss E. F. Horton, Santa Ana Community Hospital, 600 East Washington Avenue, Santa Ana, California.

Residence, Cook County School of Nursing

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. . . THEY WORK AT

**COOK COUNTY
HOSPITAL**

. . . in one of the Largest
Most Stimulating Medical
Centers in the World

Here's an opportunity to gain unique and valuable experience in a *public* hospital — world's largest for acute medical conditions. Cook County Hospital offers you the stimulation of working with more than 2,500 other doctors and nurses in one of the world's largest and most exciting medical centers. Housing is available at nominal cost. Salaries begin at *$340-$372.50* for a *37½ hour week*. And you're only minutes from Chicago's fabulous Loop and local universities.

Graduate Nurses! Write today to Director, Cook County School of Nursing, Dept. C., 1900 West Polk Street, Chicago 12, Illinois.

CALIFORNIA STATE HOSPITALS CALLING...

REGISTERED NURSES FOR IMMEDIATE EMPLOYMENT

- STARTING SALARIES $376 WITHOUT EXPERIENCE, $395 WITH ONE YEAR PSYCHIATRIC NURSING
- STIMULATING AND CHALLENGING CAREERS
- CHOICE OF LOCATION
- PROMOTIONAL OPPORTUNITIES
- REGULAR SALARY INCREASES
- LIBERAL EMPLOYEE BENEFITS

•

Eligibility for California License
and
Possession U.S. Declaration of Intention Required

•

Write Mrs. Katharine Steele

**DIRECTOR OF NURSING SERVICES, DEPARTMENT OF MENTAL HYGIENE
1320 KAY STREET, SACRAMENTO 14, CALIFORNIA**

Attention! General Duty Nurses 400-bed County Hospital located 2 hr. drive from San Francisco, ocean beaches & mountain resorts in modern & progressive city of 35,000. 40-hr. 5-day wk., 3-wk. pd. vacation, 11-pd. holidays, pd. sick leave, retirement plan & social security. Accommodations in nurses' home, meals at reasonable rates, uniforms laundered without charge. Starting salary $341 per mo. plus shift & service differentials. Must be eligible for California Registration. Write Director of Nursing, Stanislaus County Hospital, 830 Scenic Drive, Modesto, California.

Staff Nurses 600-bed general & tuberculosis teaching institution in central valley City. Accredited State & Junior Colleges in immediate vicinity, liberal personnel policies. Full maintenance available. Write — Director of Nursing Service, Fresno County General Hospital, Fresno 2, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

General Staff Nurses (Grow & develop with us) new 400-bed hospital under construction. Fully approved. Intern-resident program. Developing teaching center. Starting salary $330 per mo., $15 per mo. merit increases at 6, 12, 24 & 36-mo. 40-hr. wk., 2-wk. paid vacation, paid sick leave to 30 days; 7 paid holidays. One of Southern California's most outstanding locations. Apply: Director of Personnel, Seaside Memorial Hospital, 1401 Chestnut Avenue, Long Beach 13, California.

General Duty Nurses for 50-bed General Hospital located in college town in mountainous portion of Colorado. Salary $300 per mo. with periodic increases. Fringe benefits include meals, uniform laundry, sick leave & vacation. Registration requires 3-mo. training in Psychiatry & Pediatrics on a segregated service. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Operating Room Supervisor for 230-bed progressive J C A H General Hospital in rapidly growing town of 40,000. Salary $4,700 - $6,000 pending professional background. 40-hr. wk., week-ends free; liberal policies. Fully accredited N L N school of nursing of 50 students; faculty status B.S.. desired and/or postgraduate study required. Located 65-mi. from New York city in foot hills of Berkshires. Write: Mrs. Elsa L. Brown, Assistant administrator, Nursing, Danbury Hospital, Danbury, Connecticut.

Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $365 for days, $395 for evenings, $385 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

General Duty Nurses for 320-bed General Hospital. Only a few blocks from Lake Michigan Beach & Lincoln Park; near Chicago Loop. Hospital accredited by J.C.A.H. & school of nursing accredited by N.L.N. Apartments available close to hospital. Liberal personnel policies. Must be eligible for Ill. registration; openings on all shifts. Write: Director of Nursing, Augustana Hospital, 411 W. Dickens Ave., Chicago 14, Illinois.

Operating Room Nurses (Days & P.M.) 154-bed General Hospital located in beautiful residential suburb along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $390 days, $420 evenings, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Graduate Staff Nurses (Opportunities in the United States) for well equipped 400-bed, non-sectarian General Hospital affiliated with Medical School. New salary rates $370-$400 days & $400-$430 afternoons & nights per mo., 40-hr. wk., comfortable, low cost living accommodation in attractive residence building. Write to: Director of Nursing Service, Dept. C.J.N., Mount Sinai Medical Center, 2750 West 15th, Place, Chicago 8, Illinois.

Nurses in obstetrics, pediatrics, medicine & surgical nursing. We invite inquiries from all Canadian Nurses considering employment in the United States. For full particulars, write: Director of Nursing Service, Indiana University Medical Center, 1100 West Michigan Street, Indianapolis 7, Indiana.

Registered Nurses — Salary open, commensurate with experience, differential for evenings & night service. Openings in Obstetrical & Medical-Surgical areas. Must be eligible for registration in the State of Michigan. Apply to: Personnel Department, Woman's Hospital, 432 E. Hancock Avenue, Detroit 1, Michigan.

Registered Nurses for 85-bed voluntary non-profit hospital in growing community of 11,000. Basic salary $295 per mo. with increments of $5.00 every 6-mo. up to 2-years; 40-hr. wk.; 7 paid holidays, sick leave accumulative to 48-days; $17.50 premium for 3-11 shift, $15 additional for 11-7 shift. Apply to: Director of Nurses, St. John's Hospital of Red Wing, Red Wing, Minnesota.

Registered Nurses for fully accredited 291-bed hospital with all services, starting salary $330-$360 per mo., including ICU. Retirement plan paid, insurance & other fringe benefits. Write: Personnel Director, Washoe Medical Center, Reno, Nevada.

JEWISH GENERAL HOSPITAL

Montreal, Quebec

NURSING OPPORTUNITIES

Completion of expansion program makes available attractive positions for Registered Nurses for General Duty & also for Certified Nursing Assistants. Excellent personnel policies. Salary in accordance with The Association of Nurses of the Province of Quebec recommendations & commensurate with experience & education. Limited number of bursaries available for post-basic study after 1 year's service. Residence accommodation in very pleasant surroundings. Within 50 miles of Laurentian holiday & ski resorts.

For further information, please write:

DIRECTOR OF NURSING, JEWISH GENERAL HOSPITAL
3755 COTE ST. CATHERINE ROAD, MONTREAL, QUEBEC

DIRECTOR OF NURSING

Modern hospital 42-adult beds, 11-bassinets, located in a company operated town & serves a population of approximately 6,000. Salary range from $357 - $477 per mo., commensurate with experience & qualifications. Community organized recreation, residence accommodation & all conventional benefits available.

Apply giving full particulars of training & experience to:

ADMINISTRATOR, ANSON GENERAL HOSPITAL,
IROQUOIS FALLS, ONTARIO.

CLASSROOM & CLINICAL INSTRUCTORS
GENERAL STAFF NURSES

required

The General Hospital of Port Arthur

Salary schedule in conformity with R.N.A.O. recommendations.
Partial fare refund after 1 yr. in service.

WRITE:

DIRECTOR OF NURSING,
GENERAL HOSPITAL OF PORT ARTHUR, PORT ARTHUR, ONTARIO.

Registered Nurses (free transportation) Spend **your winter in the Sunny Southwest in New Mexico — "The Land of Enchantment". Vacancies for staff duty** in Medicine, Surgery, Obstetrics, Pediatrics & Operating Room. **Starting salaries $300** per mo., $15 differential **evenings & nights. Free transportation via 1st Class Air** to Albuquerque & return in exchange for 1-yr. employment contract. Apartment available at $17 per mo., excellent job benefits, no shift rotation. Write or **call**: Director of Nursing, Presbyterian Hospital Center, 1012 Gold Avenue, S.E., Albuquerque, New Mexico, Phone CHapel 3-5611.

Graduate Nurses (Staff & Operating Room) for 88-bed modern accredited General Hospital. Liberal personnel policies, college town 30,000, 85% sunshine belt, altitude 3,860. Dry, mild, all year climate. Apply: Director of Nurses, Memorial General Hospital, Las Cruces, New Mexico.

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

Registered Nurses (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary to start: **$339**. Pay differential for nights & **evenings**. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon.

Registered Nurses, General Duty & Operating Room (All areas & shifts available) for 165-bed JCAH Hospital, new 50-bed addition to be opened in March. Starting salary $305 General Duty, $320 O.R. 40-hr. wk., 2-3 wk. paid vacation, sick leave, nurses' residence available at reasonable rates. Excellent shift differentials. Apply: Director of Nursing, Memorial Hospital, Cheyenne, Wyoming.

Registered Nurse for 20-bed General Hospital located near San Francisco. Salary: $320-$335 per mo. 40-hr., 5-day wk., rotating shifts. Vacation with pay. Meals & room at hospital reasonable. Apply: Administrator, P.O. Box B., Gustine, California.

ONTARIO

Registered Nurses or Graduate Nurses for General Duty in modern 100-bed hospital. Basic salary $250 for R.N. 40-hr. wk., good personnel policies. Apply: Superintendent of Nurses, Smiths Falls Public Hospital, Smiths Falls, Ontario.

ALBERTA

Instructors of Nurses to teach students in 3-yr. psychiatric nursing program for 1,500-bed approved active treatment hospital. Salary range: $4,320 to $5,160 per yr. 40-hr. wk., civil service holidays, sick leave & pension benefits. Residence with board, if desired, $30 per mo. Apply, stating qualifications & experiences to: Superintendent of Nurses, Provincial Mental Institute, P.O. Box 307, Edmonton, Alberta.

MANITOBA

Registered Nurse over 30 years with at least 5-yr. experience & some administrative ability to act as Matron for modern 60-bed hospital. Salary: $360 with increments. Good living quarters. Apply: Swan River Valley Hospital, Swan River, Manitoba.

Registered Nurses for Swan River Valley Hospital. Salary: $280 with 4 semi-annual increments to $300. 44-hr. wk., 3, 8-hr. rotating shifts. 3-wk. vacation after 1-yr. continuous employment, 4-wk. thereafter. Daily bus service to points — north, south, east & west. Local golf club, flying club, curling club; good swimming, fishing, skating, etc. Apply: Swan River Valley Hospital, Swan River, Manitoba.

Registered & Licensed Practical Nurses. Salary rating for R.N's., min. $268 - max. $304 per mo.; L.P.N's, min. $208 - max $230 per mo. 8-hr. duty (day, evening or night), 40-hr. wk. Must be registered or licenced in Manitoba. Apply in writing to: Director of Nursing, Municipal Hospitals, Winnipeg 13, Manitoba.

NEW BRUNSWICK

General Duty Nurses (medical, surgical & obstetrical floors). New nurses' reesidence completed in May. Apply: Superintendent, Carleton Memorial Hospital, Woodstock, New Brunswick.

Dietitian for 75-bed hospital. Small school of nursing. Apply: Superintendent, Carleton Memorial Hospital, Woodstock, New Brunswick.

SASKATCHEWAN

Registered Nurses for Fort Qu'Appelle Sanatorium. Initial salary: $280 per mo. with semi-annual increments. Recognition for experience. 40-hr. wk., 4-wk. paid annual vacation, 10 statutory days. Sick benefits & superannuation plans in effect. Room, board & laundry, $37 per mo. Apply: Superintendent of Nurses, Fort San, Saskatchewan.

Operating Room Supervisor with postgraduate course in operating room technique for 225-bed hospital with school of nursing. Good personnel policies. Apply: Director of Nursing, Union Hospital, Moose Jaw, Saskatchewan.

TEAM NURSING IN THESE HOSPITALS!

WEST VIRGINIA
KENTUCKY
VIRGINIA

Head Nurses • Assistant Head Nurses • Team Leaders

Qualified by professional training and personality to provide administrative guidance and high quality bedside care.

Salaries at the rate of $6,420 - $5,340 - $4,860 per year depending on experience and training. Annual increases. 40 hour week. Shift differential where applicable. 4 weeks vacation. 7 paid holidays. Laundry of uniforms. Social security plus non-contributory retirement plan.

General Duty Nurses at the rate of $4,440 per year.

Write to:

MINERS MEMORIAL HOSPITAL ASSOCIATION
BOX 61, WILLIAMSON, WEST VIRGINIA, U.S.A.

GENERAL DUTY NURSES

NURSING ASSISTANTS

for all departments in a new 107-bed, 40-bassinet hospital. Gross salaries: Registered Nurses - $275. Nursing Assistants - $175. 40-hour week, 3-week vacation annually. Group pension plan & residence accommodation if desired.

Apply Administrator of

ST. JOSEPH'S GENERAL HOSPITAL, ELLIOT LAKE, ONTARIO.

CHIEF DIETITIAN

Required immediately for 280-bed Tuberculosis Sanatorium.

Salary scale is $3,630 - 100 - $3,850 per annum. Excellent working conditions, 40-hour week, paid annual leave, sick leave benefits, etc. Accommodation is available if required, for which $44 per month is deducted from salary.

Applications stating age, qualifications etc. should be addressed to:

SECRETARY, ST. JOHN'S SANATORIUM,
ST. JOHN'S, NEWFOUNDLAND

GUYS-MAUDSLEY NEUROSURGICAL UNIT

LONDON, ENGLAND

Applications are invited for the post of Theatre Sister and Staff Nurses in the above Unit. Good previous experience is necessary.

Applications to:

THE SUPERINTENDENT OF NURSING,
MAUDSLEY HOSPITAL, DENMARK HILL,
LONDON, S.E.5, ENGLAND.

THE VANCOUVER GENERAL HOSPITAL

requires

PEDIATRIC,
OPERATING ROOM &
PSYCHIATRIC NURSES

General staff positions also available.

Salary: $280 - $336 general staff. Commencing salary $294 for approved experience of 2-yrs.

Salary: Operating Room Nurses, $286.25 - $343.25.

A clinical differential of $10 a month in addition for approved postgraduate course.

4-week vacation per year.

Please apply to:

Personnel Department,
Vancouver General Hospital,
Vancouver 9, British Columbia.

REGISTERED NURSES REQUIRED

(General Duty and Operating Room)

Modern 52-bed hospital 50 miles from Ottawa in the heart of holiday resort area has openings. Commencing salary $240 per month ($10 extra night duty two weeks) all statutory holidays from employment date, three weeks annual vacation, straight 8-hour day, 44-hour week.

Private accommodation in luxurious new residence with full board and all facilities including laundry. ($25 per month only deducted for residence accommodation).

Apply

DIRECTOR OF NURSING,
PONTIAC COMMUNITY HOSPITAL
SHAWVILLE, QUEBEC

CLINICAL INSTRUCTOR

(Immediately)

For school of 75 students, 1 class yearly. Salary schedule in conformity with RNAO recommendations. Attractive residence accommodation.

Write: Director of Nursing,

ST. JOSEPH'S HOSPITAL, SUDBURY, ONTARIO.

MANITOBA

Registered Nurse (for duties of Matron), Registered Nurse &/or Practical Nurse (for general duties) for 11-bed Medical Nursing Unit. Good salaries & conditions. Apply: Lorne Memorial Medical Nursing Unit, Swan Lake, Manitoba.

ONTARIO

Registered Nurses for general duty nursing in all departments of hospital. Apply: Director of Nursing, General Hospital, Belleville, Ontario.

Registered Nurses (Operating Room & General Duty) for 20-bed private hospital. Salary: $259 per mo. plus full maintenance. Rotating shifts, averaging 42-hr. per wk. Accommodations provided in nurses' residence, single rooms. Liberal personnel policies, group ins., pension plan, 1-mo. vacation after 1-yr. service, sick leave. Excellent recreational facilities. Located in Thunder Bay district of Ontario, on main C.P.R. transcontinental line & Trans Canada Highway. Apply: Employment Supervisor, Marathon Corporation of Canada Limited, Marathon, Ontario.

Registered General Duty Nurses (Immediately) for 29-bed hospital. Salary: $265 per mo. with increments up to $295. 4-wk. vacation with pay after 1-yr. service. 8 statutory holidays. Nicely furnished nurses' residence. Apply: Superintendent, Bingham Memorial Hospital, Matheson, Ontario.

BRITISH COLUMBIA

General Duty Nurse for 25-bed modern active hospital in rapidly growing vacation land. Good recreation facilities. Friendly community scenic location in mountain valley situated on Lake Windermere only 90-mi. from Banff & Lake Louise. Nursing policies as recommended by the RNABC. Full maintenance in attractive modern residence $50 per mo. Apply: Matron, Windermere District Hospital, Invermere, British Columbia.

Graduate Nurses (Bursaries) Salary range $324-$373 after completion of 2 year training course as Radiotherapy Technician. Bursaries available during training period. First year $2,100, second year $2,200. 5-day wk., no shift work, M.S.A. 1-mo. paid vacation each year. All statutory holidays. Applicants please state age, marital status, education & nursing experience. Apply to: Miss D. M. Findley, Director of Nursing, B.C. Cancer Institute, 2656 Heather Street, Vancouver 9, British Columbia. Telephone: Trinity 4-9321.

QUEBEC

Nurse required, married or single, living near St. Joseph Blvd. & St. Denis. Permanent employment in doctor's office, 3 afternoons & 2 evenings a week. Call: VI. 5-8653.

KINGSTON GENERAL HOSPITAL

REQUIRES

Assistant Evening and Night Supervisors, Operating Room Head Nurses, for: Neurosurgery, Ophthalmology, Ear, Nose & Throat surgery.

General Duty Registered Nurses (Male or Female), for Operating Room, medical surgical floors and Intensive Care Unit.

Certified Nursing Assistants.

For full details relating to hours, vacations & benefits, apply to:

DIRECTOR OF NURSING
KINGSTON GENERAL HOSPITAL
KINGSTON, ONTARIO

HAMILTON GENERAL HOSPITALS

SCHOOL OF NURSING

will have vacancies
on the teaching staff
in the field of
SCIENCE AND NURSING
at the end of the school term

The school of nursing has a program of 2 years correlated theory and practice plus 1 year internship for approximately 300 students

Apply to: Director of Nursing,

HAMILTON
GENERAL HOSPITALS,
BARTON STREET EAST,
HAMILTON, ONTARIO.

SUPERVISOR CENTRAL SUPPLY

Required by

CITY HOSPITAL, SASKATOON, SASK.
(350 beds)

Qualifications — Registered Nurse, supervisory experience.

Duties — To supervise well organized central supply department with a large staff of nurses aides.
Orientation of nursing students and others to the department.

Liberal vacation with pay and accumulative sick leave benefits.

Apply to:

DIRECTOR OF NURSING
CITY HOSPITAL, SASKATOON, SASK.

GENERAL DUTY NURSES

for 82-bed fully accredited General Hospital. Salary $275 - $315, 40-hour week, no split shifts. Living accommodation in modern nurses' residence and uniforms laundered for $8.00 - $12.00 per month.

Will refund cost of railway fare to Canora, after 6-mo. service.

Apply to:
Superintendent of Nursing,
CANORA UNION HOSPITAL,
CANORA, SASKATCHEWAN.

REGISTERED NURSES

AND

CERTIFIED NURSING ASSISTANTS

SUNNYBROOK HOSPITAL, TORONTO
DEER LODGE HOSPITAL, WINNIPEG
QUEEN MARY VETERANS HOSPITAL, MONTREAL
WESTMINSTER HOSPITAL, LONDON
LANCASTER HOSPITAL, SAINT JOHN, N.B.
STE. ANNE DE BELLEVUE VETERANS HOSPITAL, P.Q.

Pension plan; three weeks' paid vacation; three weeks' cumulative sick leave; 5 day week; low cost living in staff residence — for Nurses. Application forms are available at Civil Service Commission Offices, National Employment Offices and main Post Offices.

For further particulars contact the Civil Service Commission Office in the province where the position in which you are interested exists —

ONTARIO — 25 St. Clair Ave. East, Toronto
MANITOBA — 266 Graham Ave., Winnipeg
NEW BRUNSWICK — Post Office Bldg., Canterbury St., Saint John, N.B.
QUEBEC — 685 Cathcart St., Montreal

WOODSTOCK GENERAL HOSPITAL
Woodstock, Ontario

requires

Registered Nurses
for Operating Room, Obstetrical,
Medical and Surgical units.

For further information write:

THE DIRECTOR OF NURSING,
GENERAL HOSPITAL,
WOODSTOCK, ONTARIO.

PUBLIC HEALTH NURSING CONSULTANT
in Tuberculosis

required by the Division of Tuberculosis Control, Department of Public Health, City of Toronto.

Minimum requirements, advanced preparation in public health nursing, degree in nursing preferred. Special preparation or experience in Tuberculosis Nursing desirable.

Salary range $5,134-$5,991. Annual increments, 5-day week, vacation, shared hospitalization, sick pay and pension plan benefits.

Apply:

PERSONNEL DEPARMENT, ROOM 320,
CITY HALL, TORONTO 1, ONTARIO.

NURSING SUPERVISORS
required for
MENTAL HEALTH SERVICES,
ESSONDALE, PROVINCE OF BRITISH COLUMBIA

Salary: $324 - $389 per month

Duties are those of nursing supervisors in modern psychiatric & geriatric units.

Applicants must be British Subjects, registered nurses, with training in a mental hospital setting & supervisory experience.

For further information & application forms, apply to:

THE PERSONNEL OFFICER, B.C. CIVIL SERVICE COMMISSION, ESSONDALE, BRITISH COLUMBIA. IMMEDIATELY. COMPETITION No. 59:152

PUBLIC GENERAL HOSPITAL
CHATHAM, ONTARIO

requires

REGISTERED NURSES

and

CERTIFIED NURSING ASSISTANTS

for

Medical, Surgical and Obstetrical Wards

for further information

APPLY TO: DIRECTOR OF NURSING,
PUBLIC GENERAL HOSPITAL,
CHATHAM, ONTARIO.

REGISTERED NURSES
AND
CERTIFIED NURSING ASSISTANTS
REQUIRED FOR

44-bed hospital with expansion program, 40-hr. wk. Situated in the Niagara Peninsula. Transportation assistance.

For salary rates & personnel policies

APPLY TO: DIRECTOR OF NURSING,
HALDIMAND WAR MEMORIAL HOSPITAL,
DUNNVILLE, ONTARIO

INSTRUCTORS
Required for
CITY HOSPITAL
SASKATOON, SASK.
(350-beds)

A nursing arts instructor and a clinical instructor in obstetrical nursing. Salary commensurate with preparation and experience. Liberal vacation with pay, cumulative sick leave, superannuation plan.

APPLY DIRECTOR OF NURSING

REGISTERED NURSES
required for
MENTAL HEALTH SERVICES
B.C. CIVIL SERVICE

Starting salary $270-$292 per month depending upon experience, rising to $325 per month. Applicants must be Canadian citizens or British subjects and registered, or eligible for registration in British Columbia.

For application forms apply IMMEDIATELY to the:

PERSONNEL OFFICER, B.C. CIVIL SERVICE
COMMISSION, ESSONDALE, B.C.
COMPETITION NO. 59:608

GENERAL STAFF NURSES
WANTED

To begin January 1, 1960
Salary Reg. N. $265 gross
100-bed hospital

Write:

THE ADMINISTRATOR,
NORFOLK GENERAL HOSPITAL,
SIMCOE, ONTARIO.

THE WINNIPEG GENERAL HOSPITAL

is Recruiting General Duty Nurses for all Services

SEND APPLICATIONS DIRECT TO:

THE PERSONNEL DIRECTOR, WINNIPEG GENERAL HOSPITAL
WINNIPEG 3, MANITOBA

HAMILTON GENERAL HOSPITALS

Assistant Night Supervisor

Applications are invited for the post of Assistant Night Supervisor for large obstetrical unit at the Mount Hamilton Hospital. Good salary, good personnel policies, pension plan. Living in reseidence optional.

Apply by letter giving full particulars to:

PERSONNEL OFFICE,
HAMILTON
GENERAL HOSPITAL,
BARTON STREET EAST,
HAMILTON, ONTARIO.

ONTARIO SOCIETY FOR CRIPPLED CHILDREN

REQUIRES

GRADUATE NURSE

To assist with the supervision of their five summer camps. Administrative ability required — camping experience preferable but not essential. Salary commensurate with experience. Employee Benefits. Permanent Position.

Apply in writing to

MISS HELEN WALLACE, Reg'd. N.
SUPERVISOR OF CAMPS
ONTARIO SOCIETY FOR
CRIPPLED CHILDREN
92 COLLEGE STREET, TORONTO
ONTARIO

GRENFELL LABRADOR MEDICAL MISSION

Positions now available for General Duty Nurses in Grenfell Mission hospitals in northern Newfoundland and Labrador. Housekeeper for modern 120-bed hospital also needed.

For full information please write:

MISS DOROTHY A. PLANT, SECRETARY,
GRENFELL LABRADOR MEDICAL MISSION,
48 SPARKS ST., OTTAWA 4, ONTARIO.

CALIFORNIA

REGISTERED NURSES

(General Duty with opportunity for advancement)

New modern 130-bed General Hospital in dynamic college city in beautiful
San Joaquin Valley only 2 hours from Los Angeles

Only evening & night positions open
Starting salary $350 per mo.
5-day, 40-hr. work wk. Progressive personnel policies.
Transportation cost to California will be reimbursed after 2-yr. satisfactory service.

Send full particulars immediately to:

DIRECTOR OF NURSING SERVICE, GREATER BAKERSFIELD MEMORIAL HOSPITAL
P.O. BOX 26, BAKERSFIELD, CALIFORNIA

SUPERINTENDENT OF NURSES

FOR

CLEARWATER LAKE HOSPITAL

THE PAS, MANITOBA

Required May, 1960. Well equipped 160-bed hospital with general and tuberculosis patients. Salary range $355-$400 per month, commensurate with experience and qualifications. Good residence accommodation and excellent personnel policies. For information and application apply:

Director of Nursing Services:
SANATORIUM BOARD OF MANITOBA,
668 BANNATYNE AVENUE, WINNIPEG, MANITOBA.

REGINA GENERAL HOSPITAL

REQUIRES

1. Clinical Supervisors in obstetrics, medicine and surgery.
2. Registered male Nurse for a program of training and supervising male nursing assistants.

Apply to:

ASSOCIATE DIRECTOR, NURSING SERVICE,
REGINA GENERAL HOSPITAL, REGINA, SASKATCHEWAN

SUBURBAN TORONTO

GRADUATE NURSES & CERTIFIED NURSING ASSISTANTS

Are invited to enquire re: employment opportunities in a well staffed new 125 bed hospital in suburban west Toronto. General duty salary range: $270-$320 per mo. Certified Nursing Assistants $200-$220 per mo. 5 day week. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL, 200 CHURCH STREET, WESTON, TORONTO 15, ONTARIO — CH 4-5551

REGISTERED NURSES

FOR THE OPERATING ROOM, OBSTETRICAL AND MEDICAL SURGICAL UNITS OF A 350-BED GENERAL HOSPITAL

Gross salary $270 - $310 per month if registered in Ontario.
Differential of $10 for evening and night duty.
40-hour week. Sick leave cumulative to 30 days.
3 weeks vacation and eight statutory holidays.

Apply:

DIRECTOR OF NURSING SERVICES,
METROPOLITAN GENERAL HOSPITAL, WINDSOR, ONTARIO

GENERAL DUTY NURSES

FOR ALL DEPARTMENTS

Gross salary $276 monthly ($127 bi-weekly) with annual increment $10 monthly ($4.60 bi-weekly) for three years, if registered in Ontario; $256 monthly ($117.80 bi-weekly) until registered. Rotating periods of duty, 40-hr. per wk., 8 statutory holidays. 14-days vacation & 12 working days leave for illness with pay after 1-yr. Pension plan available. Ontario Hospital Insurance with Blue Cross supplemental & Physicians' Services Incorporated, partial payment by hospital.

APPLY

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

THE PETERBOROUGH CIVIC HOSPITAL

REQUIRES

GENERAL DUTY STAFF

OPERATING ROOM STAFF

For further information write:

THE DIRECTOR OF NURSING
PETERBOROUGH CIVIC HOSPITAL, PETERBOROUGH, ONTARIO

UNIVERSITY HOSPITAL

SASKATOON, SASKATCHEWAN

Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week. Salary $270 to $310 gross per month. Differential for evening and night duty. Residence accommodation if desired.

Apply to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITAL,
SASKATOON, SASKATCHEWAN

VICTORIAN ORDER OF NURSES FOR CANADA

has Staff and Supervisory positions in various parts of Canada.

Personnel Practices Provide:

- Opportunity for promotion.
- Transportation while on duty.
- Vacation with pay.
- Retirement annuity benefits.

For further information write to:

Director in Chief,
Victorian Order of Nurses for Canada
5 Blackburn Ave., Ottawa 2, Ontario

NOTRE DAME HOSPITAL OF MONTREAL

NURSES NEEDED

Salary, according to qualifications: $57.00 - $90.00 per week.
Evening differential: $7.00 per week. — Night differential: $5.00 per week.
Increases: After 6 months, 1 year, 2 years.
Free: Two meals daily — Laundering of uniforms.
Statutory holidays - 2; Paid sick time - 2 weeks (after 1 year)
Paid vacation: 3 weeks after 1 year.
Opportunities for promotion — Inservice education program.

For further information, write to:

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